CENTRAL CHESHIRE OPERATIONAL PLAN 2017 – 2019

NHS SOUTH CHESHIRE CLINICAL COMMISSIONING GROUP

NHS VALE ROYAL CLINICAL COMMISSIONING GROUP

CCG Information Reader Box	
Document Purpose	For information
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Title	NHS South Cheshire Clinical Commissioning Group and NHS Vale Royal Clinical Commissioning Group (Referred to within this document as Central Cheshire CCGs and the CCGs) Operating Plan 2017/19
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Description	The Operating Plan of NHS Vale Royal Clinical Commissioning Group and NHS South Cheshire Clinical Commissioning Group outlines its operational management plans for the next two years linked to the two year Sustainability and Transformation Plan for Cheshire and Mersey. It details our approach to the stabilisation and transformation of health care in Central Cheshire and how we will improve the health outcomes and quality of care for the population.
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STP/LDP

'Overarching aim is to deliver on our purpose of creating sustainable quality services for our population'.

1. Improve the health of the C&M population
2. Improve the quality of care in hospital settings
3. Optimise direct patient care

Connecting Care

'Connecting care in communities to ensure good quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'.

1. Integrated care
2. Mental & Learning disabilities
3. Urgent Care
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5. Women & Children
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SC & VR CCGs Commissioning Intentions

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Improvement & Assessment Framework

Better Care; Better Health; Sustainability; Well Led

Chairs' Foreword

The people of Central Cheshire deserve the best NHS healthcare available. NHS Vale Royal CCG and NHS South Cheshire CCG are working hard to deliver this. We are facing an extremely challenging financial outlook, increasing demand on services and a workforce struggling to meet that demand at times.

The NHS is constantly in the news. There are claims that it is being privatised, and calls for increased funding to be made available. At a CCG level we have the task of using the resources we are given to ensure that the people we serve receive the best healthcare possible. This operational plan outlines the work we intend to do over the next two years.

You will be able to read about our local Sustainability and Transformation Plan (STP), and how our Connecting Care integration programme fits into that bigger picture. You will also read about our commissioning intentions for the period, and hopefully will be able to see that we are building on the plans of previous years, and looking to see our strategies come together.

We firmly believe that the health and social care system needs to evolve into something different and better to what we have previously enjoyed. We believe that by integrating care across organisations that we can streamline care and be more efficient. We believe that to achieve this that we need to invest in mental health, community services and General Practice in order to manage people out of hospital, to prevent the escalation to hospital services and enable people to return home as quickly as possible following any overnight stays.

You will read our thoughts about Accountable Care – about the need for health care providers and commissioners to come together and accept joint accountability for the health of the population being served, jointly making decisions about which services require investment.

There are some truly innovative ideas within the plan – the Primary Care Homes (Care Communities) have the potential to change how health and care is delivered across our towns, each tailored to the area, and in fact developed at grass-roots level from GPs working with other practitioners and the community itself.

Although we are facing significant challenges, we are also excited and can see many opportunities ahead. We would therefore like to endorse this plan to you.

Dr Andrew Wilson

GP Chair, NHS South Cheshire CCG

Dr Jonathan Griffiths

GP Chair, NHS Vale Royal CCG

Chief Executive Officer – Introduction

The Challenge Ahead

NHS South Cheshire CCG and NHS Vale Royal CCG are committed to driving a transformational approach that delivers a local health and care system that is sustainable and delivers improved outcomes for the population that we serve.

However we are doing this against a backdrop of the **most significant financial challenge** that the NHS has faced in many years. The very simple fact is that the current level of funding available does not allow us to meet the increasing patient demand if we continue to deliver services in the same way as we do now. The current scale of the gap is of such magnitude over the next five years that there is a genuine risk that it is unachievable.

Our local system of healthcare is important to us and we value it strongly, but an approach that delivers the status quo is not acceptable. There is a need for change at every single level within the system. Our approach, in conjunction with the local authorities, towards both the prevention agenda and patient empowerment has to be accelerated.

At the same time we have to expect the local hospital to change and respond to these challenges. Local people are proud of our local hospital and rightly so – but this pride must not mask the fact that if we do not change the system locally there is a very real risk that we may simply just have to cut the level of service being offered.

Our responsibility is clear – it is to commission high quality services that meet the needs of the local population within the resources that are available to us.

As I write this the very simple fact is that we are **spending more money than we are allocated** - **this is unacceptable**. As commissioners we believe adopting an approach of hard-hitting service cuts and whole-scale budget reductions will not realise any of the transformational aspects of our plans. It is our own local system transformation plans, developed and coproduced with our partners that ultimately will deliver the financial sustainability of the health and social care system in Central Cheshire. Through strong collaborative working, in combination with true patient and population engagement we will shape a sustainable future as we support the STP development.

Proactive approach: We believe in taking a proactive approach in managing our financial position; taking a very structured view of our totality of spend. We have set a budget that devolves the maximum resource available to deliver commissioned health services in Central Cheshire as well as drive the transformational change that will, if implemented fully and in partnership, return financial sustainability to our local health economy.

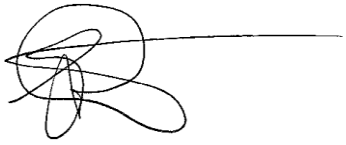
We are also committed to finding solutions that support general practice. At present it is facing unprecedented challenge both in terms of workforce and workload. The current model is unsustainable but there is clear recognition that strong general practice is at the very core of our plans for our local system.

The Connecting Care Strategic Outline Case details a compelling transformational narrative that we have to deliver at a local level. However, we cannot sit back and wait for that to happen. We will need to work with the STP footprint and will need the support and approval from both NHS England and NHS Improvement if we are to tackle some of our local challenges and make the difficult decisions. We recognise that there is a clear need to consider the future configuration for both the provider and commissioner footprint if we are to truly transform the local health and care system.

We have committed and capable clinical and managerial leaders working locally together to achieve a successful outcome. Our plans are owned by our clinicians and our staff. This is a whole organisation issue and one that is understood across our membership.
There is much to celebrate locally – we have a responsibility to ensure that we are still celebrating in five years.

Simon Whitehouse

Chief Executive (Accountable Officer)
NHS South Cheshire CCG
NHS Vale Royal CCG



Section 1 – Who we are

Cheshire represents a large geographical county covering a population of over a million residents and has a rich diversity of urban centres, market towns and rural communities. The population comprises both affluent areas and deprived areas.

The map below shows the footprint covered by NHS South Cheshire CCG and NHS Vale Royal CCG.

NHS South Cheshire CCG and NHS Vale Royal CCG cover the two local populations of Central Cheshire. The Vale Royal CCG falls completely within the boundary of Cheshire West and Chester Council and the South Cheshire CCG within the boundary of Cheshire East Council.

NHS Vale Royal CCG has a total registered population of 103,000 and compromises 12 GP practices across Winsford, Northwich and surrounding rural areas.

NHS South Cheshire CCG has a registered population of 173,000 and covers 18 member practices stretching from Audlem in the south to Middlewich in the north.

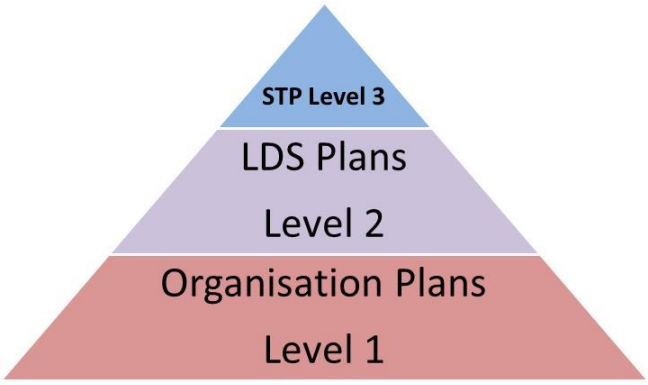
The value of the two CCG's working together as 'Central Cheshire' is in the delivery of the local agenda to improve outcomes for the population that we serve. The two CCG's working collaboratively will also ensure a clear direction of travel and support the system change that we are leading and looking to deliver. This will ensure the best use of the 'Cheshire Pound'.

Section 2 – Cheshire & Merseyside Sustainability and Transformation Plans (STP)

The Cheshire and Mersey Sustainability and Transformation Plan (STP) provides a platform for the key themes and direction that CCG's are taking in order to meet the requirements of the NHS "Five Year Forward View" and draws upon much of the work that is already underway within CCGs.

The Cheshire and Merseyside Sustainability and Transformation Plan (STP) has 3 levels:

Levels 1 and 2 are linked to the delivery at organisational level of Central Cheshire CCGs Connecting Care Plan:



The CCGs in Cheshire and Wirral are part of the Cheshire and Merseyside (C&M) STP footprint, and as Cheshire & Mersey covers a large geographical area this has been broken down into three Local Delivery Systems (LDS). These are: North Mersey, The Alliance and Cheshire and Wirral. Central Cheshire CCGs form part of the Cheshire and Wirral LDS. Working at an LDS or STP geography level as shown in the map below, aims to deliver additional economies of scale, learning and collaboration.

Key Features and Deliverables of the STP

The key challenges faced by Cheshire and Merseyside identified in the Sustainability Transformation Plan included:

- high rates of diseases associated with ageing, including dementia and cancers;
- high rates of respiratory disease;
- early years and adult obesity;
- high hospital admissions for alcohol;
- poor mental health and wellbeing; and
- high rates of teenage conceptions.

Across the region there are significant service and financial challenges, either at individual organisational level or across whole economies. Health and social care services have grown and developed over time in fragmented, uncoordinated ways that do not meet the changing needs of our communities. At the same time, there are significant pressures on health and social care budgets. These issues mean that we will fail to meet the future needs of our population and provide the standard of care they deserve without a radical change in current delivery. Continuing with current models of care provision will result in a gap in our finances of £908m by 2021 across the region if we do nothing.

Ambitions for the Patients, Staff and Population at an STP Level

- support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing;
- working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting;
- designing an acute care system for our communities that meets current modern standards and reduces variation in quality;
- making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes;

Strategic STP priorities that would make our health and care system sustainable in the near medium and long term:

a) **Improve the health of the Cheshire & Merseyside population** (previously referred to as 'Demand Management' and 'Prevention at Scale') by:
    - *Promoting physical and mental well being*
    - *Improving the provision of physical and mental care in the community (i.e. outside of hospital)*

b) **Improve the quality of care in hospital settings (previously referred to as 'Reducing variation &** improving quality in support of hospital reconfiguration') by:

- *Reducing the variation of care across C&M;*
- *Delivering the right level of care in the most appropriate setting*
- *Enhancing delivery of mental health care*

c) Optimise direct patient care (previously referred to as Productive back office and clinical support services collaboration) by:

- *Reducing the cost of administration*
- *Creating more efficient clinical support services*
-

These priorities are supported by eight clinical programmes that will look at improvement to the way we deliver:

1. *Neuroscience;*
2. *Cardiovascular disease (CVD)*
3. *Learning disabilities*
4. *Urgent Care*
5. *Cancer*
6. *Mental Health*
7. *Women's & Children's*
8. *GPs and primary care*

There are five programmes that support and enable the eight clinical programmes to change how we work together to deliver this transformation:

- *Finance*
- *Workforce*
- *Estates and facilities*
- *Technology, including Digital*
- *Communications and Engagement*

Delivery of these programmes is at LDS level, each of which has a programme of work delivering improvements locally:

The overarching purpose of these programmes is to deliver on our purpose of creating sustainable, quality services for our population.

Maximising opportunities

Our approach to delivering improvements is that opportunities will be designed and delivered at the highest level of our triangle where it can be demonstrated that this is where the greatest benefit can

be achieved. Many initiatives require a more local flavour so they will be designed and delivered locally. The emergence of an STP plan doesn't reduce the focus on organisational delivery at level 1 or the need for financial balance.

What stage are we at now?

The STP is in a design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations. We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

Section 3 - Cheshire & Wirral (C&W) Local Delivery Scheme

The current provision of secondary care is financially unsustainable and given the lack of capital, we will implement new models of care across the existing four District General Hospital sites by reviewing the urgent and planned care service models.

This will be undertaken with population health, demographics, growth opportunities and access in mind. From this evidence we will reconfigure services on existing sites so as to provide single and integrated services across Cheshire & Wirral (C&W) and within our local communities. This evidence base will also drive primary, community and mental health transformation so as to mitigate the costs of growth through demand management so as to integrate services and avoid the need for increased bed capacity. A do nothing scenario in respect of growth would indicate circa 400 additional acute beds by 2020/21.
Our triple aim is to:

- Mitigate the costs of growth,
- Give greater reliability and efficiency and
- Reduce duplication of services and sites by vertical integration, horizontal integration and reconfiguration.

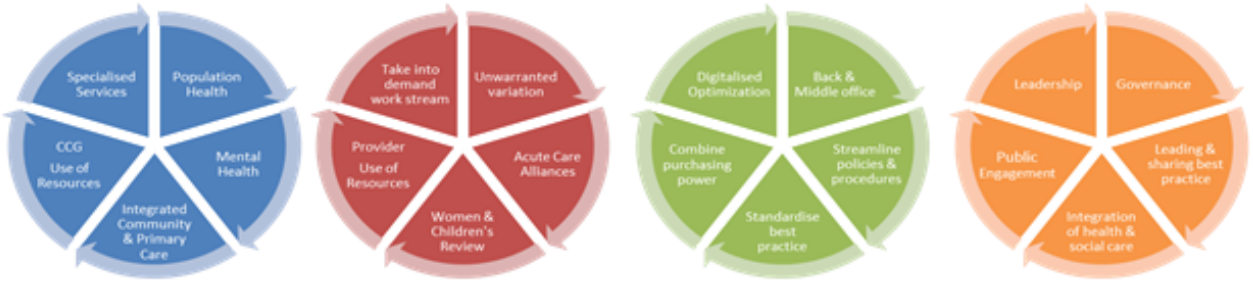
The Cheshire and Wirral plan builds upon examples of best practice including the model hospital which will develop into a model system, with a focus on reducing variation and waste, increased efficiency through greater operational transparency and control, and increased safety through high reliability processes driven by real-time clinical and operational technology platforms.

Cheshire and Wirral will invest in this real time operational performance information so that it can be used to identify and predict hospital pressures and alert status more readily. We propose to use this technology at scale to enable clinically and financially sustainable secondary care in Cheshire and Wirral.

This work is already underway with clinical alliances being formed both within and outside of Cheshire and Wirral, for example the Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) and University Hospitals of North Midlands (UHNM) formally embarking on five year programme for partnership and collaboration called `Stronger Together` and clinical integration between The Countess of Chester Hospital (COCH) and Wirral University Hospital Trust (WUTH). This demonstrates our ability to undertake secondary care transformation in the wider context of integrate services out of hospital.

We will undertake a dedicated piece of work to develop a shared understanding of the characteristics of accountable care as a natural consequence of integration.

Based on our knowledge of our local challenges, and as a result of engagement across the system, the following four priorities have been identified



Managing Care in the most appropriate setting	Unwarranted Variation Reconfiguration	Back & Middle Office Collaborations	Changing how we work together
Demand Management	**Variation / Reconfiguration**	**Back & Middle Office**	**Ways of Working**
1. Prevention £14m 2. Integrated OOH £37.9m 3. QIPP/BAU £26m 4. Accountable Care £3m 5. Specialised Services £30m	1. Variation £11m 2. Provider Chain £8m 3. Women & Child £2m 4. Accountable Care £3m 5. Model Hospital/BAU £107	1. Back & Middle Office £3.75m 2. Streamlining £1.4m 3. Best Practice £1.2m 4. Combined P`Power £22.5m 5. Digitalisation £1 m	1. Outcomes Commissioning £1m 2. Patient based need £1m 3. Systems Leadership £1m 4. Collaborative working £2m 5. Learning partnership £1m
Total £110.9m	**Total £144m**	**Total £28.8m**	**Total £6m**

The core Cheshire and Wirral ambitions by 2020/21 for Managing Care in the most appropriate settings are to:

- Implement Cheshire and Merseyside Wide Prevention strategies in Hypertension, Alcohol, and AMR.
- Implement Cheshire and Wirral wide prevention strategies for Respiratory conditions and Diabetes.
- Implement Cheshire and Merseyside Wide Neurology, Cancer and Mental Health Programmes.
- Implement a Gain Share agreement with NHSE for specialised commissioning
- Embed integrated community teams by 2017/18 that includes General Practice, Social Care and Community Services that will manage demand effectively throughout Cheshire and Wirral.
- Implement high impact demand management initiatives identified by NHSE through our current and ongoing QIPP Programme.
- Implement measures to reduce CHC expenditure by £8m
- Encourage and deliver better management of primary care prescribing (through self-care, over the counter status, repeat prescriptions)
- Continue to implement and optimise the benefit of sharing clinical information through the Cheshire (and Wirral) Care Record.
- Establish an approach to deliver Accountable Care Organisations across Cheshire and Wirral

Section 4 – Organisation Plans

Approximately 80% of the STP/LDS will be delivered at local level. Central Cheshire CCGs are working to deliver the priorities of the STP and LDS through our Connecting Care Programme. This represents Level 1 of the STP pyramid. At this level organisations are responsible for:

- Budget impact
- Managing communications
- Responsibility for delivery initiatives relating to transformation programmes

At Level 1 (CCG Geography and Communities) the responsibility to meet financial and quality standards remains.

Currently it is only at Level 1 that a budget can be impacted. Level 1 organisations also have a clear responsibility to manage communications within their organisation and to their Boards/Governors. Changes will directly impact organisations at level 1, with level 2 LDS plans providing oversight of progress, and, over time, a consolidated view of performance measures. This means that organisations in the CCGs Geography (not limited to the CCGs) are also still responsible for delivering the initiatives that relate to their individual Transformation Programmes (Connecting Care in NHS Vale Royal and NHS South Cheshire) and much of the content of the Cheshire and Wirral LDS Plan.

We believe that the work and progress that has already been made locally places us in a strong position to deliver the many challenges set out in the NHS Operational Planning and Contracting Guidance 2017-19 (published 22 September 2016).

The foundations already in place are:-

- Our **Connecting Care Strategy** has been signed off and agreed by all partners and local stakeholders. It forms the basis of our Accountable Care Organisation (ACO)/System in Central Cheshire.
- We have five Care Communities within Connecting Care, enabling better delivery of place based personal systems of care, better patient and public involvement in care commissioning and providing greater ability to address health inequalities within our area.
- We have a new community provider, made up of an alliance of our hospital, mental health and primary care providers, allowing for joint working and a mechanism to move resources around different parts of the system.
- We have delegated commissioning of primary care and an alliance of practices in place that includes all GP practices in Central Cheshire. In addition one of our Care Communities is an Early Implementer site for the Primary Care Home model of care and so we are well placed to share the learning and expand the ways of working to our other care communities.

Our work is aligned with the Cheshire and Merseyside Sustainability and Transformation Plan (STP) submission (October 2016) and our commissioning intentions detail the need for local delivery across all of our providers. We want to move to a position where we can realise the STP vision of investing in improving the resilience of our community and primary care services (GP, social care, community care and mental health) as these are essential for us to transform our system and move towards both lower cost and higher quality care delivery.

We value the importance of having a local hospital and recognise the importance of ensuring that we have local services that meet the needs of the population that we all serve. However we also recognise the very clear sustainability (both clinical and financial) issues that face all 'relatively' small District General Hospitals. Our local system is not in a financial position to underwrite the stability issues of the hospital at the expense of other services or in not developing alternatives to hospital admission to support managing demand in different ways – indeed that approach over recent years has led to a position where we have poorly developed alternatives to hospital admission.

We need to have strong integrated community and primary care that is resilient, well-resourced and is able to care for people well in a community/home setting. This approach is clearly articulated in both the STP and our Connecting Care Strategy. Our work will align with that direction of travel and in doing so will meet the requirements of the NHS Planning Guidance (2017-2019).

Section 5 - Our Commissioning Intentions 2017-19

These Commissioning Intentions set out Central Cheshire CCGs commissioning plans for 2017 to 2019 for all of our providers. We are not starting from scratch but are building on the foundations laid over the past 24 months.

We will monitor the effectiveness of our commissioning plans and any impact on services and finance via: Executive team meetings, Directorate meetings, Governing Body and Membership meetings. Timelines will be established for delivery of these commissioning intentions and they will be monitored for progress and delivery outcomes.

Our commissioning intentions set out how we expect providers to work differently in order to address the 3 fundamental gaps detailed in the NHS Five Year Forward View (FYFV):-

1. **Health & well-being** - if we fail to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness
2. **Care and quality** - unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist
3. **Funding and efficiency** - if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments. Our system allocation is set and explicit

It is clear that we need to implement common sense actions that will deliver a better NHS for our local population. We want to really drive forward prevention at scale, increase the number of GP's locally whilst evolving the GP workforce model; increase the community mental health service offer with additional staff working locally; improve the end of life care provided so that we see a continual increase in the number of people dying in their place of choice and we need to support an increasing number of people being cared for in the community by developing and investing in local community services. We want high quality local secondary care services that meet the needs of the population and that are affordable, whilst we also ensure that more complex pathways make sense for patients and deliver improved outcomes. We expect the majority of care for the residents of Cheshire to be provided in Cheshire and close to the patient's home. This will lead to demand being managed differently and should demonstrate a clear 'channel shift' as to how care is both delivered and received.

The NHS Planning Guidance sets the need to deliver financial recovery and sustainability. We welcome that and, in addition, it states that "all organisations are responsible for delivery of their own total AND overall system control", as with this in place we are ready to implement a changed model of care outlined in our agreed Connecting Care Strategy.

The CCGs need to deliver in excess of £30m savings in 2017/18 across all areas of expenditure to support the delivery of the system control total and to ensure that the local system is able to live within its allocation. This is a non-negotiable position given the Legal Directions that NHS South Cheshire CCG are currently functioning under. As such all contract offers will need to be affordable for the system in their totality.

The development of our Connecting Care Accountable Care Organisation (ACO) with its Care Communities within it, will allow this to happen but we have to increase the pace of local delivery and implementation. The localities and sense of place allows us to contribute, with public health colleagues, on developing improved population health as well as personal responsibility for health and wellbeing. We will have a focus on commissioning services that offer alternatives to hospital care both for elective and urgent care and will expect providers to challenge and reduce unwarranted clinical variation (using RightCare and other recognised benchmarking tools in systematic ways to drive an improvement in clinical standards). We will develop personalised care for patients allowing them more choice in the care and interventions they wish to receive especially as they approach the end of their life. For our patients with multiple long-term conditions we will have a holistic approach to their care so that all their needs, physical mental social are addressed together, rather than sequentially or in silos.

Accountable Care

The delivery of care via an accountable care structure is a core principle of the Connecting Care Strategy and the jointly agreed Strategic Outline Case. We will expect providers to realise this vision with the delivery of a Multi-Speciality Community Provider (MCP) that will;

- Establish locality working within our Care Communities
- Establish Care Community Central Support;
    - **Clinical**
        - Diagnostic support
        - Intermediate care
        - Linked specialist access including EOL specialist support
        - Rehabilitation
        - Ambulatory care unit

        - Medical assessment centre
        - Surgical assessment centre
        - Possible Emergency department

    - **Support to Clinical Services**
        - Business intelligence
        - Leadership
        - Quality improvement and change management Support

- Use a Primary Care Home model of care that develops person centred individual care, as well as influencing health and wellbeing at population level
- With our focus on integration and collaboration we will make use of the Community Services MCP 2016/17 transformation program to deliver a shift in care from hospital to community based services
- We will commission pathways that provide alternatives to hospital care
- Work with providers to develop and establish appropriate governance and contracting arrangements to support the implementation of the ACO
- Our intention is to move to a multi-speciality community provider organisational form to drive forward both the local integration and accountable care agenda
- Support the Sustainability and Transformation Plan (STP) and ensure that all local plans are aligned to the work streams.

The Connecting Care Board meeting (26th October 2016) confirmed the approach of developing an ACO based on the registered list of General Practice and using the partnership formed as a result of the recent re-commissioning of community services as the vehicle to drive forward our local system approach. We will commission for a new model of accountable care and set out a framework for the delivery of this during this planning round.

Pioneer Programme

The CCGs are members of the Cheshire-wide Pioneer Programme, via the Connecting Care, through which a range of projects are being delivered for the benefit of all transition programmes in Cheshire.

The Pioneer projects include:

- Workforce initiatives to support service connection and integration; development of staff through a range of learning and improvement activities (with Innovation Agency support); and working with the wider workforce community (including colleges, University, local authority and NHS providers) to coordinate initiatives.

- Cheshire Integrated Digital Care Record to enable Cheshire-wide browsing of an individual's care record when appropriately consented, to enable more seamless care transfers and delivery

- Public engagement to support individuals maintaining better and taking their own steps to promote their health and wellbeing

There has never been a stronger need for all of our providers to work collaboratively and to put organisational boundaries to one side. We expect to see significant and real change taking place locally that is able to realise cost savings for the system as a whole. Consolidation of back office functions, full delivery of the Carter review and internal cost improvement programmes (CIP's) will not get us to a balanced position alone. All providers have a responsibility to go further and to be more robust in driving out savings for the system to enable us to live with the allocation. This will involve different partnerships and different formal relationships where control is ceded to other partners. Over recent years the commissioning part of the system has undergone significant change and reconfiguration – it is clear that this approach in isolation is not delivering the necessary scale of change or delivery. On this basis there is a need to use the opportunity afforded to us through the STP process to drive forward system change (provider reconfiguration and provider consolidation) and to recognise that the current model of care delivery locally is not sustainable in its current form.

We will commission services in primary and community care that empower staff to suggest changes to improve ways of working that will deliver both improved patient care and more affordable patient care. We will have mechanisms to share good practice with the other care communities. We will encourage new models of care to encourage a range of first point of contacts for patients, e.g. physiotherapist, community pharmacist, third sector organisations. This will make for more efficient and responsive patient care and develop a sustainable work force as Central Cheshire is seen as a good place to work.

As detailed all plans are required to support the delivery of a sustainable healthcare system and link to the objectives within the local Connecting Care Programme, which in turn, reflects the Cheshire and Mersey Sustainability and Transformation Plan (STP). The management and adherence to the NHS Constitutional Standards will be paramount to ensure good patient experience, access and care. We will consult and engage widely with our patients and public about changes in our services and will want our Care Communities to help facilitate this. We will engage on what local services can and cannot deliver and get support and understanding for what we can afford with our Cheshire Pound.

The key objectives in 2017-19 is the successful delivery of these transformation plans which provide a step-change in the way we commission services and require providers to work together, providing multi-disciplinary teams to better support patients within an affordable healthcare system. The result will be a reduced reliance on acute care with patients better able to manage their own conditions and able to access expert support at home.

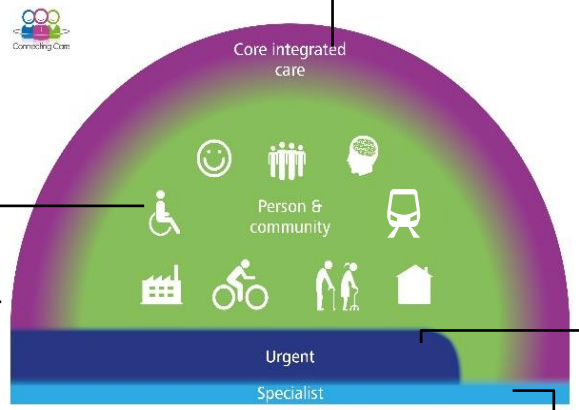
Connecting Care – Proposed Care Model

Person & community

The framework is centred around the person and how they wish to live within their communities. The person's community is to some extent self-defined as each person's will be different.
In the vision for 2021, people will be supported to meet their health and wellbeing goals through improved public health information and messages reinforced through multiple channels within the community – schools, employers, clubs, societies and other organisations.

Core integrated care

The 'core integrated care' team consists of the local team members of all organisations who are involved in the care and support of the wellbeing of the identified community being served. This spans social and health care organisations. It requires professionals to commit to working together and for senior responsible officers (SROs) to expedite solutions to actual or potential barriers on behalf of their organisations. The vision for 'core integrated care' by 2021 is one of joined up, co-ordinated care where services are built around the person; rather than people fitting into the services.



Urgent care

Urgent care is accessible 24/7 either through contacting a needs co-ordinator or attending an urgent care facility. The needs co-ordinator is well-trained to assess and advise on the situation, and facilitate access to additional care and/or services as needed.

A person with escalating needs who requires assessment or support

Non-urgent: If the person believes they require a non-urgent assessment or service, they will contact their 'needs co-ordinator' who is able to quickly assess and direct the person to the appropriate services within their community without a referral.
Urgent: If a person believes they require urgent assessment or treatment, they will choose to either contact their 'needs co-ordinator' within the 'core integrated care' element for condition specific advice or will attend an urgent care facility directly.

Specialist

Specialists are part of the core integrated care team to ensure seamless delivery of care. Specialist expertise is provided through direct access to specialists and/or through remote support. Members of the core-integrated team may be trained in certain specialties and specialists are also trained in generalist care approaches.

Connecting Care Blueprint

The following blueprint illustrates a more integrated way of delivering services. New and existing services will be delivered at three different levels of care, with each level of care serving a different population size. The three levels of care, also referred to as the three integrated networks, reflect the delivery of services to empower an individual to meet their care and support needs by networks of professionals, care givers, volunteers etc. These have been summarised below:

Scale required for the service to be sustainable:
Services will be delivered at the most local level possible

Central Cheshire Wide Team

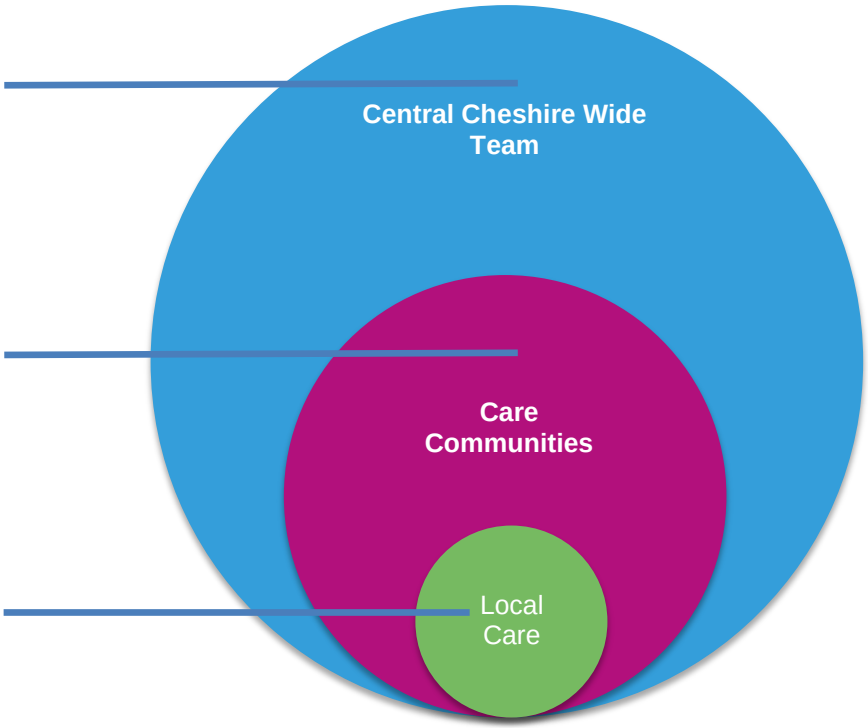
- Includes new and existing services delivered in the acute setting or co-delivered by the care communities and/or other organisations
- Select services may be delivered outside Central Cheshire, e.g. through Cheshire and Wirral Partnership and tertiary services.

Care Communities

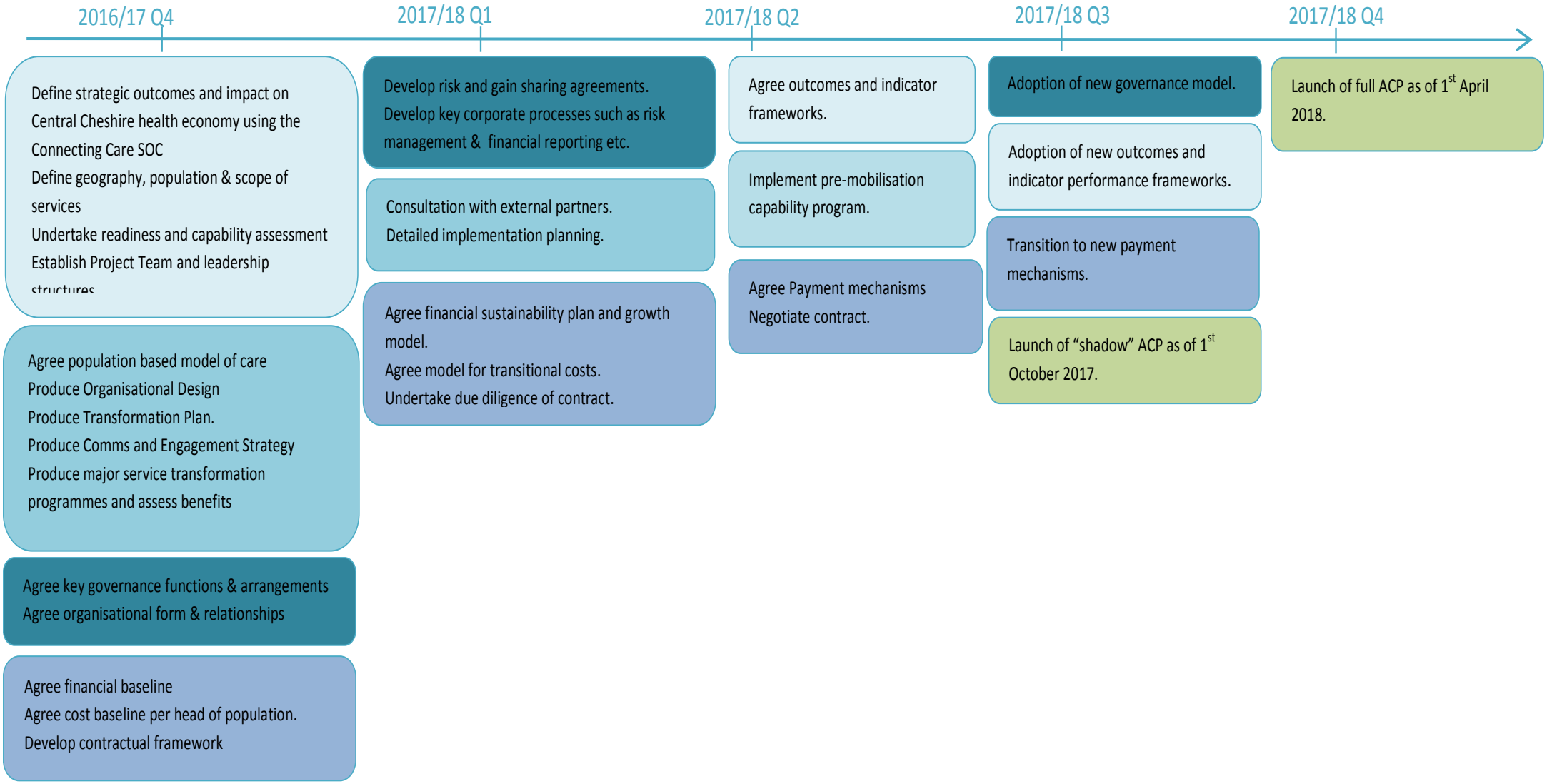
- A Care Community is an extended integrated support and care team that is built up of Local Care services alongside secondary care professionals.
- This team works together to deliver new and existing services in a joined up way with the third and private services and the communities it serves
- Delivered through shared values and ways of working, including virtual team
- Operates in a defined geographical area
- Outcomes and performance measurement will take place

Local Care

- This level reflects services that are already being delivered by GP's, nurses, pharmacists, dentists, social workers, and carers in the third sector
- Individuals meet with the above professionals as determined by their needs
- Services available vary by practice
- Most practices will be part of a Care Community



Central Cheshire ACO Plan



Commissioning Intentions

Primary Care Home/Care Communities

The Primary Care Homes (Care Communities) objective is to provide care to a defined, registered population of between 30,000 and 50,000 via Integrated Community Teams; to have a combined focus on personalisation of care with improvements in the health outcomes of the population; to have an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and to align clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards. 2017/18 will see the establishment of Primary Care Home/Care Communities across South Cheshire and Vale Royal, and these will be based around clusters of GP Practices that will be fully sustainable by 2020. In order to do this, the CCGs will work with partners to:-

- Provide a community response to long-term condition management delivering new care models
- Provide community care to frail older people through the sustainability of the GP Care Home Service as part of Primary Care Home
- Transform primary care delivery with increased patient access and promotion of personalised self-care
- Use technology to improve care co-ordination and communication
- Provide a social and cultural context to public health promotion
- Develop the scope of capitated budgets in the community with clear accountability/ delegation with the Clinical Commissioning Group and shadow budgets from 2017/18
- Develop and implement a Primary Care Charter to support Primary Care Home sites to transform Primary Care for future sustainability

We will continue to work with the Connecting Care Multi-speciality Community Provider as part of the wider Connecting Care Community to establish the best contracting and delivery mechanisms for an accountable care system as part of the Connecting Care Vision and STP.

Delivering Productivity and Quality

The CCGs intend to seek sustainable improvement in the productivity and quality of care in organisations. CCGs will look to utilise the National Quality Board resources to measure and improve safe, sustainable and quality productive services.

The CCGs are required to meet their statutory obligations in all areas and, to do so will be required to de-commission services where clinical evidence is limited or the services are not able to demonstrate the continual improvement in outcomes for the local population. De-commissioning

will be aligned to the policies of neighbouring CCGs wherever possible and Quality Impact Assessments will be undertaken to support all decision making. The CCGs will adopt a de-commissioning policy and will apply public engagement and consultation processes as appropriate for the size, scale and impact of any de-commissioned services.

In the aim to deliver control totals and the vision of shared efficiencies, the CCGs will look to implement a shared pharmacy budget across organisations. This will facilitate productivity gains to ensure there are no perverse incentives for organisations and a key component of this is ensuring all clinicians work collaboratively to deliver this vision. The joint learning gained from this will help shape and scope additional areas across the STP footprints.

As detailed the current approach of internal organisational specific CIP programmes will need to continue but on top of that there is a need for a strong focus on additional CIP activity that will release system wide savings.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. These will impact on reducing inequalities in access to services, the experiences of using them and the outcomes achieved. The design of the 17/18 scheme will be influenced by the ambitions of the Five Year Forward View (FYFV).

CQUIN in isolation will not address these issues, but if aligned with the Connecting Care Programme and the Sustainability and Transformation Plans (STPs) covering the whole health and social care systems, it can be a strong lever to help bring about changes: to deliver improved quality of care to patients through clinical and service transformation. The CCGs are explicit in stating that they expect to see CQIN resource used to drive change and improve quality – it is not about supporting a baseline position resulting in doing more of the same.

To deliver the FYFV, organisations will move to a more place based approach, geared towards transforming services to deliver better quality standards for patients, improving the working environment for staff, and delivering financial balance.

The national indicators will reflect these priorities:

- NHS staff health and wellbeing (all providers)
- proactive and safe discharge (acute and community providers)
- reducing 999 conveyance (ambulance providers)
- NHS 111 referrals to A&E and 999 (NHS 111 providers)
- reducing the impact of serious infections (acute providers)

- wound care (community providers)
- improving services for people with mental health needs who present to A&E (acute and mental health providers)
- physical health for people with severe mental illness (community and mental health providers)
- transition for children and young people with mental health needs (mental health providers)
- advice and guidance services (acute providers)
- e-referrals (acute providers, 2017/18 only)
- preventing ill health from risky behaviours (acute providers 2018/19 only; community and mental health providers, both years)

To deliver Connecting Care commissioners will use the local CQUIN quantum to finance transformation priorities linked to the delivery of the operational plans and the five-year STPs. We will also utilise the Right Care data identifying variation to inform the development of CQUINS and Quality Schedule.

Continuing Healthcare

We intend to strengthen our approach to Continuing Healthcare, Funded Nursing Care and Complex Care by working at scale during 2017 and beyond. This scale approach will improve outcomes for people, their families and carers who use this service.

NHS South Cheshire, NHS Vale Royal, NHS Eastern Cheshire, NHS West Cheshire and NHS Wirral CCG's have developed an NHS Continuing Healthcare (CHC), NHS Funded Nursing Care (FNC) and NHS Complex Care (CC) Strategic Plan 2016 – 2018.

Alongside this there is an established CHC Joint Committee attended by all 5 CCGs and Wirral, Cheshire West & Chester and East Cheshire LA's which acts as a Joint Health and Social Care decision making body for CHC, Complex Care and Funded Nursing Care.

Implementation of this strategic plan will build upon the work which has already commenced across Cheshire and Wirral and will strengthen people's confidence and pride in the service.

In addition, there is agreement across partners with regard to CHC affordability and the QIPP initiatives required 2017/18:

- Efficiencies will be underpinned by 5 work streams:

- Reviewing High cost cases
- Implementing in all cases Contractual mechanisms / price challenge
- Decreasing Out of area placements
- Increasing Personal Health Budgets
- Person Centred Joint packages of care

Primary Care

The CCGs will commission safe, high quality and timely primary care services for the population. To do this we recognise the challenges that individual practices, and general practice as a whole, are facing and we will need to support them to deliver the Five Year Forward View for General Practice.

We understand that solutions may be different for different practices, but that an open transparent and fair system will be in place to make sure the whole population has access to good quality care.

We see the future of General Practice as the beating heart of care communities as outlined in the Connecting Care Strategic Outline Case. Care communities will deliver care to primary care principles (person centred, holistic care that is comprehensive and delivered with continuity) and will be the main delivery units of our multi-speciality community provider. Further detail on this is provided in the Accountable Care Section.

The multi-speciality community provider model is built on the registered list of GP practices. There is inherent resilience, flexibility and capability built into the self-managed professionally led teams in GP practices. This should not be undervalued. However, for some practices rationalisation in the form of merger with other practices or even for some the MCP structure maybe the best way to secure the best quality & sustainable services for the population. This will be supported where it is requested by practices.

In this extended role General Practice teams will deliver extended care, in collaboration with other generalist community based primary care and specialists colleagues that will increase the 'comprehensive' nature of the care offer and prevent the need for higher intensity and more costly care alternatives.

There will be plans for Practice Transformational Support including the 10 high impact changes. We also expect a consistent quality and access offer across practices and we expect GP services to expand in scope to meet new challenges and to deliver better outcomes. In reality this means that our Practices may deliver care via the current model of small autonomous teams but our expectation is that we require competent organisational and wider sector outcomes from this. Our clear intention is that, as CCGs, we expect to be dealing more with our Practices as a collective, via the GP Alliance, than as individual Practices. On that basis we recognise the need to support the GP Alliance to play its full part in these changes as outlined in the planning guidance.

A new contract offer, additional to GMS/PMS; the " Primary Care Charter", will support this vision for local Primary Care Services and will set out what local people should expect from local services. This contract will bring into one place the expectation and support for GP practices supported by monies previously labelled as transformation (NHS Planning Guidance), local quality & nursing home schemes, when possible it will include Access payments (GP Access Fund).

The CCGs will support Primary Care with the alignment of the resources, including technology, to underpin the changes required to tackle workforce and workload and support Primary Care at scale. The CCGs will continue to support the progress made with the development of the alliance of general practices, and to support it to develop its key role as a provider organisation in our new community provider alliance.

Medicines Optimisation

The Medicines Management Team (MMT) will develop a QIPP plan to further address medicines waste by ensure prescribing and dispensing decisions are appropriate and that systems that support them are as efficient as possible.

The Team will focus on several main areas to achieve this

- Continue to review the current prescribing choices clinicians make and provide advice that seeks to ensure more cost-effective prescribing whilst maintaining quality.
- Work with our community provider to consider transferring the prescribing of certain specialist products, such as urological catheters, stoma care, dressings and nutritional feeds, from General Practice to the relevant clinical experts in their field. Elsewhere this has both improved the quality of the service that the patient receives whilst reducing waste and thus overall cost.
- Continue the work with clinical specialists, both locally and regionally, to implement web-based prior-approval systems (Bluetec) that can help both Trusts and CCGs demonstrate compliance with NICE Technology Appraisal Guidance and locally agreed pathways.
- Engage with community pharmacy on commissioned services (e.g. the Think Pharmacy Minor Ailments Service) and other joint working opportunities (e.g. promoting self-care and improving the management of repeat prescription processes for people with long term conditions).

Within each of these areas the objective is to look at introducing efficiencies through transformation and system change at the same time as maintaining or improving quality and effectiveness.

Community Services

As part of the transformation of community services, during 2017/18 the CCGs will be commissioning, via the Central Cheshire Integrated Care Partnership (CCICP), comprehensive reviews and service change implementation in:

- GP-Out of Hours provision
- Community Rehabilitation Services
- Intermediate Care Services
- Musculoskeletal Clinical Assessment and Triage
- Community nursing and district nursing services
- Integrated Community teams
- This work will be integrated into the Primary Care Home/Care Communities development, and ensure that the CCICP contract supports integration in the community.

Integrated Intermediate Care

To deliver the vision of the Connecting Care Strategy, the CCGs will continue to work with partners to implement an integrated intermediate care service across Central Cheshire. To deliver this by April 2018, the CCGs will lead;

- Development of opportunities to work in collaboration with the third sector to meet local population need
- Implement a single point of access for rapid response
- Contribute to the community beds needs assessment across Cheshire

As outlined in the Strategic Outline Case for Connecting Care, the CCGs will be continuing our work in 2017/18 to implement integrated intermediate care services across Central Cheshire. To this end, 2017/18 will see the commissioning of a rapid response service with a single point of access for anyone with an urgent need that does not require admission by June 2017.

Elective Access

Commissioners will continue to build on the work developed in 2016/17 based on the RightCare pathways. Indeed RightCare will become the preferred method of commissioning and providers will be expected to align their delivery profile to the national and peer benchmarks. This will support the STP approach towards reducing unwarranted clinical variation. We will further explore and implement opportunities for improved patient care, whilst delivering a sustainable healthcare system. We will continue to explore all opportunities to drive efficiency, improve access and support patients with self-care and health promotion and prevention. We will look to support the realignment of resources to manage the change in service delivery from acute to community services. A continued focus on referral management will continue with the intention of strengthening the processes and monitoring of all referrals – we expect providers to manage referrals to ensure that we meet the contracted activity plans. Over performance will not be paid for.

Urgent Care Transformation and Commissioning

In 2016/17 the CCGs identified a need to review the demand for urgent primary care and effectively meet the urgent care needs of the local population. By transforming the emergency department front door, increasing provision of urgent primary care though practices and urgent care centres, the CCGs plan to lead a multi stakeholder programme of work to increase access to primary care, develop telehealth opportunities and diagnostic capabilities within the community.

The increase in access will lead to better clinical care for patients and better standards of care across South Cheshire and Vale Royal. The CCGs will work with partners to;

- Transform the Emergency Department Front Door, to quickly understand people's needs and direct them to the appropriate care setting
- Improve and extend patient access to urgent primary care (Prime Ministers GP Access Fund), to offer joined up, high quality services delivered by practice teams to keep people out of hospital
- Develop an approach for Urgent Primary Care Centres where patients have access to urgent diagnostics and an ambulatory care service, as an alternative to the hospital Emergency Department

NHS South Cheshire CCG and NHS Vale Royal CCG are committed to delivering improvements to the quality and outcomes for our local population requiring Urgent and Emergency Care. A program of work has been developed for implementation in 17/18 that support partnership working and will lay the foundation stones for the Transformational Urgent Care work that will be delivered through the Connecting Care Board and STP. Three core areas of work have been identified to support this:

- Ambulatory Care Service
- Emergency Department Front Door Streaming
- Falls Prevention

During 2017-19 the CCGs will commission the transformation of urgent care services in Central Cheshire; ensuring transformation reduces demand placed on local A&E and ambulance services through the effective provision of primary and community service models of care. In undertaking this work the CCGs will ensure ambulatory care commissioning supports optimal care pathways for patients. This step change will see organisations working across boundaries in a place-based care model described in our Connecting Care strategy.

Stream-line Discharge Processes

Across Central Cheshire, the CCGs will continue to work with health and social care commissioners and providers to stop Delayed Transfers of Care, and ensure people are discharged from hospital appropriately and with the support they need to be safe in their home or place of residence. To do this, the CCGs will work with partners over the next two years to;

- Develop and implement an integrated frailty pathway
- Redesign of health and social care services that support rapid response for those in need of urgent care close to home.
- Develop and implement the Discharge to Assess model with acute trust and community providers
- Implement an integrated safe transfer of care model
- Develop and implement a health and social care integrated discharge team for Central Cheshire

- During 2016/17 the CCGs are working to deliver Central Cheshire integrated discharge team, primary/community care led post discharge reviews as well as a “discharge to assess” approach to support step down provision.
- In order to continue this work for effective discharge planning in 17-19 the CCGs will:
- Commission a Frailty Pathway for Central Cheshire by July 2017
- Establish phased introduction of “trusted assessor model” to improve transitions across health and social care systems by July 2017

The CCGs will require providers to submit weekly reports highlighting patients with delayed transfers of care. This information will enable Commissioners to support providers with delivering safe and streamlined patient discharge. The system solution is the only route to resolve this issue and not one organisation working on its own can.

Digital Transformation

In line with the digital transformation agenda throughout the NHS, the CCGs will seek assurance and action from Providers that all patient records will be integrated electronic records to deliver efficiency, safety and collaborative provision of care.

The CCGs will require Providers of consultant-led services to work at pace to ensure all specialties and ***clinical prioritisation are fully published in the Directory of Services to enable e-*** referrals. We require the secondary care clinical teams to actively review and triage e-referrals on receipt and offer an advice and guidance service through this system in order to help ensure that use of secondary care services is appropriate and productive whilst also ensuring that primary care is fully supported in managing patients.

We expect that all providers will move to using nhs.net as the email system of choice and to move away from individual organisational email systems during the 2017/18 year.

We expect all providers to fully engage with the Cheshire Shared Digital Care Record and to ensure that their own local systems are fully compliant and are able to share clinical information.

No provider should procure or change any IT system without ensuring its compatibility with EMIS.

Adult Mental Health, CAMHS, Learning Disabilities and Dementia

As outlined in the Strategic Outline Case in Connecting Care the CCGs will continue to work to deliver true parity of esteem for mental health conditions. This means improving the physical health outcomes for those with severe mental illness or a learning difficulty, and improving the mental health of patients with physical health problems and multiple long-term conditions. We will deliver our part of the implementation plan of the Mental Health Five year forward view.

NHS South Cheshire CCG and NHS Vale Royal CCG are committed to delivering a transformation in mental health for our local population. The evidence indicates that improving outcomes for people with mental health problems at an early stage supports them to achieve greater wellbeing, build independence and resilience and optimise life chances, as well as reducing premature mortality. Implementing the commitments of this framework will improve access and outcomes, move towards the delivery of all age seven-day services, reduce inequalities and realise efficiencies across the local health and care economy.

The Five Year Forward View for Mental Health, Children's and Young people's Mental health transformation plans as well as Transforming Care for Individuals with a learning disability and/or Autism all highlight the need for care closer to home and personalised services based on individual need. The CCGs are committed to ensure all individuals receive good quality and safe services.

Expansion of Gateway Teams

We will expand the primary care mental health service (Gateway) into dementia and liaison psychiatry services and ensure they are embedded within general practice. Within care communities we will look at place based wellbeing and resilience; embracing the model of 5 steps

Dementia Care

We will raise the profile of dementia to both increase diagnosis rates, and improve the quality of care for people with this diagnosis and their families and carers. We will expand the Dementia Adviser role and also ensure access to dementia advice and nursing care for integrated community teams. We will also ensure access to brief interventions for people with dementia, particularly after a short hospital admission, to try to support people to stay in their own homes.

We will continue the work of the dementia end of life partnership; supporting people and families in relation to their wishes to die in own home, hospice or nursing home. By developing these changes in dementia care we expect providers to demonstrate and deliver:-

- A 20% reduction in A&E attendances for dementia related conditions
- A 40% reduction in non-elective admissions for dementia related conditions

Mental Health Crisis Care

We will build on the work of our Street Triage service this year to develop and expand our offer for adults and young people experiencing a mental health crisis. This is will be partly via the Gateway service offering support in the crisis but also being accessible and preventing crises occurring. The CCGs, along with partners are working to deliver the Mental Health Crisis Concordat.

We will have a zero tolerance of police cells being used as place of safety for people who are mentally ill. Alternatives to hospital admission for people in crisis are being considered, (e.g. commissioning of a Crisis House and “Mind Sanctuary"). We will continue to work to deliver the Pan Cheshire Zero Suicide plan. The aim is to ensure that there are alternative places of safety for those experiencing a mental health crisis, and where possible maintain people in their own home.

The CCGs will ensure that mental health is considered and integrated into business planning processes for urgent care. We expect providers to be able to demonstrate:-

- An 8.7% reduction in unplanned admissions for mental health conditions
- A 30% reduction in non-elective average length of stay for mental health conditions

Learning Disability

During 2017-19 the CCGs will see the continued implementation of the transforming care partnership plans with local government partners for Learning Disability provision. This work builds on the progress made during 2016/17. The CCGs will review the inpatient bed capacity for learning disabilities, with the aim to increase community provision through a sustainable and affordable approach and meet local patient needs.

To work collaboratively with Primary Care to ensure patient with learning disabilities have appropriate access to annual health check to ensure their health needs are being met. The purpose is to ensure that the health resource is appropriately aligned to match the patients’ needs that may vary year on year. This will include:-

- Reducing inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population
- Improving access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check
- Reducing premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism

Children and Young People Mental health

During 2016/17 the CCGs continue to work on delivering the CAMHS Transformation plans. 2017/18 will see the continuation of service transformation and delivery of the 'Future in Mind' objectives.

Women and Children

Commissioning for women and children will focus on the objectives set out in the appendices. The primary focus for maternal health and children will be subject to the outcomes of the Maternity Review being undertaken by the Cheshire and Merseyside Vanguard. The CCGs will consider the recommendations and the actions required to deliver sustainable paediatric and maternal health services for our population and may reflect any changes to the work programme as a result of the recommendations.

Cancer

During 2017-19 the CCGs will continue to work on the Central Cheshire Cancer Strategy 2016 – 2020 as well as implement the Cancer Taskforce report led by the Cancer Alliances and the National Cancer Vanguard.

NHS South Cheshire CCG and NHS Vale Royal CCG are committed to delivering improvements to the quality and outcomes of Cancer Care for our local population. A local Cancer Strategy has been developed for Central Cheshire that provides an ambitious plan across partners to improve cancer outcomes. This aligns with the Sustainability and Transformation Plan (STP) within Greater Manchester as this is where the majority of cancer pathways flow. Cancer is the biggest cause of death in adults in South Cheshire and Vale Royal with mortality significantly higher in men than in women.

There are also significant differences in survival and mortality from cancer across towns in the CCGs. Both NHS South Cheshire CCG and NHS Vale Royal CCG were 2 of the top 20 CCG's across England to have made the most improvement in the latest published 1-year survival from cancer across England. However, there remains a lot of work required to improve this cancer outcome further. Early diagnosis of cancer is a critical factor for best patient and cancer outcomes. Cancers that are diagnosed late are usually due to early signs and symptoms either not recognised or not acted upon, uptake to cancer screening programmes and lifestyle factors. The cancers that require priority focus in Central Cheshire around early diagnosis are lung cancer, upper GI cancer and colorectal cancer.

Outcomes required are summarised below:-

- Cancers classified as being preventable reduced to 52% by 2020
- Increase to 62% the percentage of cancers diagnosed at stage 1 or 2 by 2020
- Increase to 75% the percentage of people diagnosed with cancer surviving to at least 1 year by 2020
- Increase to 57% the percentage of people diagnosed with cancer surviving to 10 years by 2020
- Increase uptake to bowel cancer screening to 70% by 2020

Programmes of work:

- Diagnose cancer early
- Ambitions and Performance
- Reducing the growth in the number of cancer cases
- Improving survival
- Redesign of the Upper GI cancer pathway
- Achieving NICE Improving Outcome Guidance for the Urology cancer pathway
- Risk stratify End of treatment cancer pathways and develop self-management / remote monitoring support for Breast, Colorectal and Urology pathways
- Ensure of areas of the Recovery package are commissioned to support cancer patients including follow-up.

End of Life services and pathways will be a particular focus of our commissioning intentions with the following objectives and outcomes required from providers. The objectives are set out later in the document.

Care Homes

The CCGs are committed to commissioning high quality, safe and person centred care in the community – we recognise that some of our most vulnerable patients are cared for here and we intend to bring a specific focus on this area of the health and care system over the next two years. Part of this work involves gaining the assurance that we have Nursing and Residential homes in the local area that are able to provide the right care, have well trained and skilled staff and are supported to ensure residents have choice and control on where they wish to live and the care they receive.

The CCGs intend to work with local partners including Mid Cheshire NHS Trust and the Local Authorities to ensure we have a nursing home market that can meet the needs of the population. The Joint Strategic Needs Assessment shows an increase of 57% of residents who may require 24hr Care in a care home over the next 10yrs, and significant increase in demand for dementia care.

As part of the CCGs committed we are also working with community' services, quality assurance teams, CQC and Health watch to ensure that nursing and residential homes have the right training in place for staff at all levels to be able to provide appropriate care for residents. Over the next two years a number of transformation project initiatives will take place to address some of these. This will include:

- more robust information on the current use of community bed-based care and placement activity
- agreement on an appropriate and sustainable mix of home based care, reablement, extra care housing support and bed-based provision to meet the needs of older people over the next 3-5 years
- an estimate of the overall systemic cost of meeting forecast demand and agreement on how the overall cost can best be apportioned and managed

- commissioning and operational plans to deliver care to meet forecast demand.
- Working closely with the Local Authority to improve the quality of life for residents in care homes and expand choice and options in the Market for residents who will require a higher level of support.

Contract Management

The CCGs, in conjunction with MCHFT, set out an agreed position to move away from a PbR contract for 2017/18. This remains an essential component of the CCGs' commissioning intentions and plans to help support demand management in the local system and to drive different behaviours to help get grip and control in the local system. A PbR contract will be seen as a system failure as there is common acceptance that the system control total (the CCGs' Allocation) will not be delivered by adopting a growth strategy to drive single organisational survival at the expense of the system. Every other contract is currently on a block arrangement and the direction of travel towards capitated accountable budgets for population health means that PbR is out-dated and drives perverse incentives.

The local health system will be required to live within the CCGs allocation and no contracts will be agreed that place that at risk. For NHS South Cheshire CCG this is a national Legal Direction as detailed by NHS England. All providers will be expected to work together to ensure that contract values are delivered and stay within the detailed allocations. We will only pay the agreed contract value in each of the next 2 years, and will expect providers to work collaboratively to support the management of demand and activity to a level that meets the contract value.

Full validation and checks will continue to be applied throughout 2017/18 and 2018/19. The CCGs will also introduce additional requirements for providers to validate their invoices across all sectors. These challenges and validations will ensure that all activity can be referenced to a specific GP referral and that policy thresholds and commissioned waiting times have been applied and adhered to before payment is made. These requirements are set out in more detail later in the appendices.

For all providers the CCGs will:-

- withhold payment to Providers who change services or changes to naming of services where there has been no agreement made with the CCGs and underpinned by a contract variation

- require the Providers to move towards a payment based on SUS data to enable effective utilisation of resources available to organisations

- withhold payment for excess bed days which have been caused through patients having inappropriate length of stay / delayed discharges when alternative offers of appropriate care at other organisations have been offered and patients have remained in an inpatient hospital bed

- withhold payment where full evidence cannot be demonstrated of full engagement with incentive schemes (all sectors) and showing a resultant change in behaviour or activity profile as an outcome from that engagement

This 2017-19 Commissioning Intentions document sets out the priority and visions for the central Cheshire system. The document is aimed at all of our providers so that that a whole system approach can be adopted. The expectations around collaboration, sharing of information and true joint working are clear throughout this document and this supports the Connecting Care Strategic Outline Case.

Quality Premium 2017/18

NHS South Cheshire CCG and NHS Vale Royal CCG are committed to full participation in all aspects of the Quality Premium scheme published in 2017/18. The two year scheme intends to reward NHS South Cheshire CCG and NHS Vale Royal CCG for achievement of measures that cover a combination of national and local priorities. There are gateway tests for quality, finance, NHS Constitution and six mandated indicators, early cancer diagnosis, GP access and experience, continuing healthcare, mental health, blood stream infections and one local indicator focussed on the RightCare programme. The schemes will complement the work already underway in the CCG to improve patient outcomes, reduce inequalities in health outcomes and improve access to services. The Quality Premium oversight will be considered at the Quality and Safety Committee and then to Governing Body for executive decisions.

Section 6 - Other Key Areas of Focus for 2017-19

Better Care Fund

The Better Care Fund has been established by the Government to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives.

It is a requirement of the Better Care Fund (BCF) that the Partners establish a pooled fund for this purpose. The Better Care Fund was established for the first year in 2015/16, operating under section 75 arrangements. Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of defined local authority functions and defined NHS functions.

The overall goal is that by 2020, there will be better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG Improvement and assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the Government's key criteria for devolution.

In line with the Operational Planning Guidance a joint plan will be agreed to deliver the requirements of the Better Care Fund (BCF) for 2017/18 and 2018/19 via the Health and Wellbeing Board.

CCGs are advised by NHS England of the minimum amount that they are required to pool as part of the notification of their wider allocation.

The plan will build on the 2016/17 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. The joint plan supports reductions in unplanned admissions and hospital delayed transfers of care.

Better Care Fund Metrics identified in the Operational Planning Guidance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services
Delayed Transfers of care per 100,000 population (attributable to NHS, social care or both)
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Proportion of patients with a Personal Health Budget based on number of patients and demographics

The Summary of Schemes is shown below:-

NHS South Cheshire CCG

Scheme Title:	**2016/17** **£000**	**Draft 2017/18** **£000**	**Draft 2018/19** **£000**
Supporting empowerment	102	*102*	*102*
Universal access to low level support	167	*167*	*167*
Assistive technology - telecare	235	*235*	*235*
Assistive technology - learning disability pilot	118	*118*	*118*
Early discharge schemes	170	*170*	*170*
Dementia Reablement	303	*303*	*303*
Carers breaks	200	*200*	*200*
Carers assessment	152	*152*	*152*
Integrated Community Teams (South Cheshire)	1,350	*1350*	*1350*
Transitional Care (Intermediate Care & Reablement)	7,431	*7431*	*7431*
Cheshire Care Record	146	*146*	*146*
Community Equipment Scheme	322	*322*	*322*
Social Care Act	185	*185*	*185*
Programme Enablers	142	*142*	*142*
TOTAL	**11,023**	***11,023***	***11,023***

NHS Vale Royal CCG

Scheme Title:	2016/17 £000	Draft 2017/18 £000	Draft 2018/19 £000
Tackling Social Isolation	61	*61*	*61*
Support to Carers	198	*198*	*198*
Single Point of Access	97	*97*	*97*
Integrated Community Services	997	*997*	*997*
Managing Immediate Demand in Acute	695	*695*	*695*
Transitional Care (Intermediate Care & Reablement)	4,376	*4376*	*4376*
Supporting People to Live at Home	278	*278*	*278*
Introducing the Care Act	337	*337*	*337*
TOTAL	**7,039**	***7,039***	***7,039***

Note: (correct at 24th Nov 16) the BCF Guidance has not yet been issued so the minimum values have not yet been notified for 2017/18 & 2018/19. The Schemes for 2017/18 & 2018/19 are under review with partner organisations.

Supporting our Workforce to Deliver

NHS South Cheshire CCG and NHS Vale Royal CCG have restructured their teams and Executive Directors portfolios to reflect the current NHS landscape and the key priorities defined, with an eye to the future arrangements that best fit the organisational purpose. Active engagement with staff and clinical leads has taken place to understand the views that are important to them through a staff culture survey. We also hold monthly briefing sessions, led by Executives, with staff to ensure communication is maintained across the two CCGs and hold regular staff awards scheme to recognise the good work that is happening across our teams.

Learning and Adapting

We have made good progress against our two year “People/OD Strategy” drawing from our plans for transformation, organisational development and communication and engagement. Implementation of these plans will build our capacity for change and development of our

workforce. The strategy covers the period 2016/18 with a supporting implementation plan addressing our key themes and priority areas. Priorities for action in 2017/18 include:

Staff development to support integration and collaborative commissioning: The Central Cheshire

Pioneer programme, which includes Connecting Care, secured additional funding in 2015 to undertake work to align training and development of staff across the system, to support service integration. Workforce initiatives to train and develop staff together to increase their 'system knowledge' and integrative working, is the aim of the project. 2017 will see the implementation of initiatives to increase integration through training and development of staff including:

A Clinical Leaders for Transformation Programme: We have worked with the North West Leadership Academy and AQuA to develop a six month programme designed for senior clinical leaders from primary care, mental health and secondary care. The aim of the programme that began in June 2016 is to create a group of clinical leaders who will champion the role of clinical leadership in their localities and support delivery of transformational change aligned to the CCG's strategic priorities. A second cohort of this programme is being considered for 2017 and will also partner with colleagues from provider organisations.

Governing Body Development Sessions: In 2016 we focused on establishing regular Governing Body development sessions which encompassed strategy, governance, and shared values. These quarterly sessions will continue in 2017/18 and will set the tone for the CCGs leadership style. The development sessions will reflect the requirements for active engagement and demonstration of collaborative commissioning and leadership around a shared purpose.

Development of Talent Mapping, Succession Planning and Associated Training Needs Analysis:

We have begun the process of developing a Talent Mapping/Succession Planning model. This will be aligned to the existing PDR process and supported by an appropriate learning and development process and plan. The talent mapping strategy will take account of individual performance and aspirations, and build a sustainable future for the organisation, and clinical leadership. The creation of a training needs analysis (TNA) and supporting learning and development plan will capture the skills and capabilities required to meet the strategic objectives and identify any gaps in current capability.

Communication and Engagement

NHS South Cheshire CCG and NHS Vale Royal CCG believes that working together we can be outstanding by communicating and sharing in an open and honest way, empowering our local communities by giving an opportunity for each individual to be involved and making engagement meaningful and valuable.

Our aim is to:

- Engage with and consult our patients, their carers and families as well as our general population and stakeholders before any change to services and before any new service is developed
- Involve our local population in shaping the future of local healthcare
- Lead a collaborative approach to communications and engagement with our service partners
- Ensure consistency of approach in the cascade of information within our CCGs and across our local health economy
- Ensure we have robust process in place to be able to respond, deal and tackle media interest in our services
- Commit resources to be able to innovate and keep up with the pace of change for digital communications and engagement

We have always had a real desire to make a difference for our patients and public with a focus on improving outcomes and ensuring that every single 'Cheshire pound' of tax payer's money that we commit, on behalf of the Government, is used wisely and with greatest impact. We take that responsibility seriously and we care about our local NHS.

Over the coming months we will continue to place our patients at the heart of the work we do and we will continue to ensure that everyone in our local community has an opportunity to work to shape the future of local healthcare. We want to have an open and honest conversation with local people, engaging with them at every step of our journey towards financial balance.

The following examples clearly demonstrate our approach to engagement and involvement in our commissioning work;

***Health Forum*:** The Vale Royal Health Forum is a vital meeting to keep patients and the public at the centre of our decision making processes, chaired by our lay member Governing Body representative for public participation. The forum is very well attended and is made up of a vast range of people from local communities and populations. This includes patients, members of Vale Royal Patient Participation Groups (PPGs), stakeholders, council representatives, carers and members of Cheshire West Healthwatch, making the forum a genuine champion for the local population of Vale Royal.

***South Cheshire PPG Federation*:** The Federation of Patient Participation Groups is a reference group that is made up of the PPGs from the GP Practices in the local area. The Federation provides an effective mechanism through which PPGs can work together to share issues, ideas, information, support and good practice with other PPGs, whilst also improving communication and engagement and raising awareness of local health services, developments, projects and opportunities for involvement.

***Clinical and Professional Senate*:** This senate works to ensure the 'frontline' voice of professionals, clinicians, patients and carers is heard within the commissioning and provider cycle. This group also ensures that our transformation programme is able to move forward at pace with an emphasis on the right clinical focus and population challenge and feedback.

***Winter flu clinic engagement*:** Understanding the impact of interactions and information sharing with our local population we utilise the opportunities of the large patient numbers attending the flu clinics across the Central Cheshire area. At these clinics we work to build an understanding of the CCGs across patients as well as positioning possible changes ahead.

***Public and patient involvement*:** The CCGs hold patient and public involvement in high regard and believe that true success occurs when we share, involve and engage with our local population. We have a real desire to make a difference to our local communities and want to enable all residents to have a voice in local health services and decision making. Public involvement in commissioning is about offering people ways to voice their needs and wishes, and to influence plans, proposals and decisions about their NHS services. Patients and the public can often identify innovative, effective and efficient ways of designing and delivering services if given the opportunity to provide meaningful and constructive input.

Patient stories: The CCGs have worked to develop of a database of patient stories as a means for patient experiences to be shared. Patient stories share insight into how patients, family members, carers and employees feel about their healthcare and help the CCG and providers understand a patient pathway and how this fits into their everyday life. As well as adding further clarity, patient stories allow us to appreciate and understand insight and experiences as not just individual processes but as part of a whole journey. We continue to use patient stories at the start of public Governing Body meetings and have developed this approach to include shared experiences from patients and their families and carers. The experiential story telling is always linked to the key items on the agenda allowing an opportunity to set the patient at the centre and to allow their experience to directly influence the way our governance and decision making is completed.

Membership Council/Assembly: In both CCGs monthly membership meetings are held, which have a representative from each practice. These meetings are chaired by each CCG's GP chair and their purpose is to share information, best practice and local based issues. These monthly meetings also provide the GP membership with an opportunity to be involved in commissioning either at Governing Body level or working on specific clinical projects.

Healthwatch: Across Central Cheshire we work closely with both Healthwatch Cheshire East and Healthwatch Cheshire West to support them in their work to understand the needs, experiences and concerns of our local population in relation to healthcare services. Healthwatch also acts as our 'critical friend' adding a level of scrutiny and speaking on behalf of our local population.

Working across both NHS South Cheshire CCG and NHS Vale Royal CCG both Healthwatch organisations produce a quarterly reports, providing feedback and verbatim from our local patient populations. These reports are then fed into the CCGs Quality and Performance committee accompanied by updates from the CCG's own engagement and involvement team.

The Governing Body lay member for patient and public involvement for each CCG takes a lead in driving the relationship with Healthwatch, enabling a clear mechanism to allow patients the opportunity for their healthcare needs to be heard and understood. In order to develop this a patient experience programme is in place to work as part of our complaints and quality team's toolkit to allow us to reference patient experience and identify key themes across the CCGs and Healthwatch.

- All organisations should implement plans to improve quality of care, particularly for organisations in special measures.
- Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.

Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.

Engagement, Consultation and Communication approach for our patients and public

Formal Consultation

Use for decommissioning and service change. E.g.

- IVF
- Sterilisation
- Cosmetic surgery

Approach

Join consultations together across themes and local footprints following a strict & legal 12 week approach. Ensure that all partners and stakeholders are tied in to the consultation and that they run in parallel to existing engagement conversations to continue narrative. Always reference back to existing feedback – e.g. Cheshire Chat

Channels

Use electronic survey method to allow easy call to action & to collate & analyse results. As well as this, always have a focus on face to face & hyperlocal conversations, considering unique opportunities such as 'pop up stands' in the heart of communities. Media still has a key role but vary to also include digital & social as well as film & animation

People

Utilise the hard-won existing relationships & networks including an opportunity to revisit key relationships made in Cheshire Chat. Draw on expert & informed patient networks & PPGs as well as Health Forums & stakeholders participation networks. Ensure a strong working relationship with Healthwatch.

Engagement

Use for the majority of projects. E.g.

- Urgent Care
- Repeat prescriptions

Approach

Collaboratively themed ensuring key aims of 5YFV are embedded as well as our key areas locally:

- Hospital
- Community
- Medicines
- Mental Health

Always reinforcing a hyperlocal approach, ensuring that all partners and stakeholders are tied in to the consultation which should always run in parallel to existing engagement conversations. This continues the narrative and embeds a pan health & social care collaboration.

Channels

Primarily use face to face marketplace sessions as well unique 'pop up' stands in key locations such as flu clinics to raise profile. Consider Innovative ways working across partners – e,g. bus journeys as well as personal opinion in the form of blogs and vlogs. Maintain relationships with traditional media but develop digital & social in parallel.

People

Targeted full stakeholder list to be developed, revisiting key relationships made in Cheshire Chat. Draw on expert & informed patient networks & PPGs as well as local communities. Ensure a strong working relationship with Healthwatch.

Communications

Regular, aligned comms always referencing our projects and our activity. E.g.

- Positive news stories – gateway, AoC, street triage, Clinical pharmacists

Approach

Reinforce the overall good work of the CCG with positive news stories on a little & often basis. Have key aims of 5YFV running as a golden thread throughout with an emphasis on our open and honest approach. Consider uniquely designed infographic to support key messages if appropriate or needed.

Channels

Utilise all our existing channels as they are highly visible and easily accessible to our population. These include: Website, Social & digital media, Traditional media & Radio Use developed relationships with partners and stakeholders to allow replication and sharing of news stories. Look to make the most of editorials & health/social care specific journals.

People

Blanket and saturated full coverage of local community, ensuring full communication with 9 PC in language, approach & channels that are accessible to them. Make the most of our existing & informed Health and social care audiences

Engagement, Consultation and Communication approach for our patients and public

Cheshire Care Record

During 2017/18 the CCGs will continue with expansion of the Cheshire Care Record project through additional data sharing agreements and technical changes. This system that currently enables seamless sharing of patients' data across health and social care providers in Cheshire will be extended to allow other organisations to both submit and have access to digital patient records. It is anticipated that the Cheshire Care Record will be expanded to include:

- Electronic Palliative Care Co-ordination System (EPaCCS) template for End of Life Diagnosis
- Integrated access for the current Out of Hours Clinical system
- Provision of access to the three Hospices in Cheshire and integrate their relevant clinical data
- Continue to work with other Health and Social care agencies, NWAS, Continued health Care, Fire service to expand the data available
- Inclusion Community Services data
- Expand Acute datasets to include electronic information for Radiology Reporting, Electronic Clinical Letters, Pathology results etc.
- Implement real time updates from GP Clinical System of Choice (EMIS)
- Continue to promote to Patients through expanded communication and media routes

Cheshire Shared IT Network (MPLS)

During 2017/18 we will look to complete the collaborative work with our new ICT supplier and BT to integrate the network across the Cheshire Pioneer footprint, this includes CCGs, GP Practices and Acute Providers. This will bring benefits of integration to Health and social care organisations, cost savings, additional resilience, and act as an enabler for new projects like remote working through Virtual Desktop integration. The project is planned to run from January 2016 until September 2016 with elements of benefits realisation delivered throughout the lifecycle of the project and beyond to the organisations involved.

- Increase the capacity and speed of the network connections at all sites
- Utilise Government standard PSN (Pubic Services network) design to allow connectivity to other Health and Social Care Networks, Fire & Police services
- Enable the delivery of Public Wifi in all GP Practices across South Cheshire and Vale Royal
- Promote the use of Video consultations with the increased network capacity
- Reduce costs across Cheshire for Providers and CCG

- Act as a key enabler for the Local Digital Roadmap ambitions of Interoperability for Cheshire & Wirral

Section 7 – Finance and the Financial Recovery Plan for 2017/19

NHS South Cheshire CCG and NHS Vale Royal CCG are in a financially challenging position and have been in this position in 2016/17.

In 2016/17 NHS South Cheshire CCG has been in legal directions to meet its control total deficit of £3.440 million. NHS Vale Royal although not in legal directions has been operating in a deficit position, £1.990 million and has consequently been under a high level of financial scrutiny.

NHS South Cheshire CCG has had to produce an Organisational Improvement Plan which has been agreed by NHS England to provide assurance that its governance, leadership and financial systems are robust.

As a matter of good practice NHS Vale Royal CCG financial management is being carried out to the same standard as that in NHS South Cheshire CCG.

The CCGs continue to have a significant financial challenge in 2017/19. The CCGs are taking action to address the underlying deficit position present in each CCG.

7.1 Allocations and Funding Changes

7.1.1 In 2016/17 the CCGs received 5 year allocations which can be seen in Figure 1 and 2 below. This shows that the CCG allocations have been increased by 2% growth in 2017/18 and 2018/19. Both NHS South Cheshire CCG and NHS Vale Royal CCG have a negative distance from target and so they are effectively underfunded by 3.9% and 3.3% respectively.

7.1.2 Currently both CCGs will be in deficit in 2016/17, NHS South Cheshire by -£4.680million, NHS Vale Royal by -£2.503million. Although both CCGs, under the guidance of NHS England, are holding a 1% non-recurrent reserve which will be used to improve this position at the year end.

7.1.3 The CCG allocations although fixed for five years have been adjusted for two specific items in 2017/18:

- Identification Rule Changes for Specialist Commissioning

The changes relate to national changes to those services identified as being specialist to ensure consistent application of the identification rules. The changes are mainly based on 2014/15 activity uplifted to 2017/18 baseline. The details provided to the CCG in relation to these changes have yet to be verified and due to their nature and previous experience are likely to contain a high level of risk to the CCG. No monies have been set aside to cover any additional risk due to incorrect pricing or the incorrect identification of activity levels.

- The impact of HRG 4+ changes

The modelled impact of the changes to prices in the 2017/18 and 2018/19 National Tariff notably the move to HRG4+ and changes to the tool and method used for top-ups; this is effectively a new allocation of activity based on the recorded patient minimum data set and the applied tariff based on the national reference cost data collection.

Figure 1

South Cheshire CCG - 01R						
CCG	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Allocation	212,888	219,961	224,367	228,825	233,581	242,130
Allocation per capita		1,217	1,237	1,257	1,279	1,321
Growth %		3.30	2.00	2.00	2.10	3.70
Per capita growth %		3.00	1.60	1.60	1.70	3.30
Target		229,453	233,564	237,535	241,970	250,500
Target per capita		1,270	1,288	1,305	1,325	1,367
Opening DFT %		- 3.40	- 3.50	- 3.30	- 3.00	- 2.80
Closing DFT %	- 4.10	- 4.10	- 3.90	- 3.70	- 3.50	- 3.30
Primary Medical						
Allocation	21,987	22,771	23,190	23,638	24,232	25,164
Allocation per capita		126	128	130	133	137
Growth %		3.60	1.80	1.90	2.50	3.80
Per capita growth %		3.20	1.50	1.60	2.20	3.40
Target		21,928	22,553	23,191	23,885	24,781
Target per capita		121	124	127	131	135
Opening DFT %		4.40	4.60	3.60	2.60	2.10
Closing DFT %	3.60	3.80	2.80	1.90	1.50	1.50
Specialised						
Allocation	37,174	39,866	41,625	43,325	45,104	47,208
Allocation per capita		221	229	238	247	258
Growth %		7.20	4.40	4.10	4.10	4.70
Per capita growth %		6.90	4.00	3.70	3.70	4.30
Target		36,714	38,334	39,898	41,535	43,472
Target per capita		203	211	219	227	237
Opening DFT %		9.40	9.40	9.40	9.40	9.40
Closing DFT %	8.60	8.60	8.60	8.60	8.60	8.60
Total						
Allocation	272,049	282,598	289,182	295,788	302,916	314,492
Allocation per capita		1,564	1,594	1,625	1,659	1,716
Growth %		3.90	2.30	2.30	2.40	3.80
Per capita growth %		3.50	2.00	1.90	2.10	3.50
Target		288,094	294,451	300,624	307,390	318,754
Target per capita		1,594	1,623	1,652	1,683	1,739
Opening DFT %		- 1.20	- 1.20	- 1.10	- 0.90	- 0.80
Closing DFT %	- 1.90	- 1.90	- 1.80	- 1.60	- 1.50	- 1.30
Population						
Population Projection	180,085	180,711	181,375	181,993	182,629	183,256
Population Growth		0.30	0.40	0.30	0.30	0.30

Figure 2

NHS Vale Royal CCG - 02D						
CCG	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Allocation	124,013	127,900	130,462	133,054	135,819	140,790
Allocation per capita		1,231	1,253	1,275	1,299	1,344
Growth %		3.10	2.00	2.00	2.10	3.70
Per capita growth %		3.00	1.80	1.80	1.90	3.50
Target		132,748	134,901	136,993	139,320	144,019
Target per capita		1,277	1,296	1,313	1,333	1,375
Opening DFT %		- 2.90	- 3.00	- 2.60	- 2.20	- 1.90
Closing DFT %	- 3.60	- 3.70	- 3.30	- 2.90	- 2.50	- 2.20
Primary Medical						
Allocation	12,065	12,505	12,735	12,981	13,320	13,806
Allocation per capita		120	122	124	127	132
Growth %		3.60	1.80	1.90	2.60	3.60
Per capita growth %		3.50	1.60	1.70	2.40	3.40
Target		12,550	12,887	13,232	13,605	14,095
Target per capita		121	124	127	130	135
Opening DFT %		0.10	0.40	0.50	1.20	1.40
Closing DFT %	0.80	0.40	1.20	1.90	2.10	2.00
Specialised						
Allocation	22,035	23,590	24,590	25,556	26,560	27,759
Allocation per capita		227	236	245	254	265
Growth %		7.10	4.20	3.90	3.90	4.50
Per capita growth %		6.90	4.00	3.70	3.70	4.30
Target		21,932	22,861	23,759	24,693	25,807
Target per capita		211	220	228	236	246
Opening DFT %		8.40	8.40	8.40	8.30	8.30
Closing DFT %	7.60	7.60	7.60	7.60	7.60	7.60
Total						
Allocation	158,113	163,995	167,787	171,591	175,699	182,355
Allocation per capita		1,578	1,611	1,645	1,681	1,741
Growth %		3.70	2.30	2.30	2.40	3.80
Per capita growth %		3.50	2.10	2.10	2.20	3.60
Target		167,230	170,650	173,984	177,618	183,921
Target per capita		1,609	1,639	1,668	1,699	1,756
Opening DFT %		- 1.30	- 1.20	- 1.00	- 0.70	- 0.40
Closing DFT %	- 2.00	- 1.90	- 1.70	- 1.40	- 1.10	- 0.90
Population						
Population Projection	103,736	103,919	104,127	104,328	104,519	104,724
Population Growth		0.20	0.20	0.20	0.20	0.20

7.2 CCG Allocations

7.2.1 The table below shows the movements between the CCGs 2016/17 allocation and their allocation for 2017/18:

Description	NHS SCCCG (£'000)	NHS VRCCG (£'000)
2016/17 Allocation	247,428	144,099
Non Recurrent Adjustments	-866	-1,493
Growth in Core/RC Allocation	4,393	2,551
Growth in Delegated Allocation	419	230
HRG4+ Non Recurrent Adjustment	-1,516	-737
Identification Rules Non Recurrent Adjustment	1,883	802
2017/18 Allocation	**251,741**	**145,452**

7.3 Business Rules and Directions – NHS South Cheshire CCG

7.3.1 As NHS South Cheshire CCG is under Directions the CCG is required to comply with the directions given by NHS England in that:-

'South Cheshire CCG shall ensure that in the financial year 2016/17 it achieves an in-year deficit of no more than £3.4m and how it will operate within its annual budget for the financial year 2017/18 and thereafter';

7.4 Business Rules - NHS Vale Royal CCG

7.4.1 The business rules for NHS Vale Royal require the following:-

'CCGs that will not meet the cumulative/historic 1 percent underspend requirement are required as a minimum to improve their in-year position by 1 percent of allocation per year plus any growth above average until cumulative deficit repayment has been completed and 1 percent cumulative underspend business rule is achieved. Any CCG that is not currently

meeting the cumulative underspend requirement is expected to plan to do so over the strategic planning period.

Any CCG that does not submit a plan that meets these requirements will be entered directly into the special measures regime.'

7.4.2 Both of the above result in the CCGs requiring a balance position in year with the possibility of carrying forward, but not reducing the brought forward deficit from 2016/17.

7.4.3 The CCGs have asked NHS England for clarity on the points raised above as these requirements do not align to the requirements within the Sustainability and Transformation Plan (discussed below) which state that footprints must reach a balanced position by the end of 2020/21.

7.5 Sustainability and Transformation Plan.

7.5.1 The CCGs have submitted baseline 'do nothing' scenarios for the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside. The plan requirements and those for the individual CCGs in respect of Directions and business rules are not completely consistent; the CCGs in all cases have followed legal directions and the NHS planning guidance.

7.6 Control Totals

7.6.1 Nationally the NHS has indicated that it will be looking at the introduction of system wide control totals. The CCGs are interested in this approach:-

- To sustain the commitment to collaboration developed across health economies and reduce the incentives for individual organisations to optimise their own financial position at the expense of the wider system as the focus moves to operational planning and delivery;

- To create the flexibility for local systems to implement transformational change without being constrained by any resulting shifts in financial performance as between individual organisations;
- To maximise the likelihood of success in managing overall financial delivery risk in the system by fostering shared risk management approaches across health economies.

7.6.2 This would mean that the CCGs and local providers would work together to have a single control total made up of their individual control totals and aligned with the STP control total. Local management arrangements would need to be in place across the system to allow flexibilities in applying the control total.

7.6.3 Whilst the above is an ambition it is unlikely to be realised in year.

7.7 Operational and Contracting Plan Guidance 2017-19

7.7.1 The operation plan guidance has been issued by the NHS and includes the financial assumptions and investment requirements for the NHS.

7.7.2 The Planning and Contracting guidance covers a period of 2 years.

7.7.3 As in previous years the CCGs will be required to set aside a non-recurrent 1% of which 0.5% must be uncommitted at the start of the year. The other 0.5% should be made available for investment non-recurrently.

7.7.4 The CCGs will also need to set aside 0.5% as a recurrent contingency.

7.7.5 CQUIN is 2.5% of the contract value as in previous years; however this is allocated as 1.5% for nationally defined CQUIN, 0.5% for the Trust to deliver their involvement in the STP and 0.5% to be held non-recurrently in an uncommitted reserve until the provider is told how to spend the monies. The Trust will receive the uncommitted reserve at the start of 2017/18 should they meet their control total in 2016/17.

7.7.6 The inflationary tariff uplift in 2017/18 is 2.1% with an efficiency requirement of 2.0%. in addition there is a recurrent pressure of an additional 0.7 % due to the increased costs related to the clinical Negligence Scheme for Trusts.

7.7.7 There are a number of national non recurrent monies which can be bid for in year. There is no current guidance on how these monies may be accessed however it is important that the CCG access these funds to enable service transformation.

7.7.8 Non recurrent monies subject to national requirements:-

- Technology Fund £4.2 billion
- £15.0 million 2017/18 and £20.0 million 2018/19 for GP IT
- Diabetes funding £40.0 million
- Care navigators and medical assistants £45.0 million in 3 years
- General Practice Resilience funding £40.0 million over 2 years
- £6.00 per head recurrently for Prime Ministers Access Fund for those practices currently in the scheme, for those not in the scheme there will be £3.34 provided in 2018/19 recurrently
- Mental Health central funding, £215million in 2017/18 and £180million in 2018/19

7.7.9 There are also a number of investments the CCGs are required to fund from their baseline allocations:

- £3.00 per head non-recurrently to GP Practices over 2 years
- Mental Health Investment fund

These have been included in the CCG plans for 2017/9.

7.7.10 There is an opportunity to develop a gain share with the specialist commissioners within the guidance and this will be pursued.

7.7.11 In addition to the monies outlined above there are a significant number of requirements in the operational and contracting guidance for the development and changes to the current provision of services which are supportive of or in addition to the plans set out in the STP.

7.7.12 The CCG will also need to maximise any opportunities for sourcing additional funds to support transformation, this will need to include the achievement of the Quality Premium.

7.8 Financial Assumptions

7.8.1 Each area of budget has been assessed and the additional inevitable increase in cost has been assessed together with the associated QIPP to ensure the CCGs remain within the business rules.

Budget Area	Assumption
Prescribing	5% activity and price and 2% QIPP
Continuing Care	National assumption of 5% growth
Acute Services	3% activity growth and QIPP
Mental Health	0%
Primary Care	National Guidance 1.8%
Running Costs	0%

7.9 Partnership Working

7.9.1 Better Care Fund

The CCG entered into a Section 75 agreement under the Better Care Fund for 2015/6 and is looking to work together with the local authority to develop an extended pooled budget in 2017/19. The CCGs and both local councils, Cheshire East Council and Cheshire West and Chester Council have worked closely in the last year to develop relationships and understanding in order to allow greater integration to occur. The minimum contributions for the BCF were released on the 16th December and therefore discussions on what items will be included within the BCF in the coming two years are now underway (Summary of the funding based on 16/17 figures are shown on page 44 and 45)

7.10 Prescribing

Primary care providers within NHS South Cheshire CCG and NHS Vale Royal CCGs have always maintained a focus on efficient and effective prescribing; the specific details of the medicines management actions to control expenditure are developed throughout the year in consultation with CCG member practices.

The inflation recommended for prescribing has been maintained at 5%, with a QIPP target of 3%. The Medicines management team have developed an incentive scheme which delivers considerable levels of productivity which will assist in bringing the CCG back into financial balance.

7.11 CHC

There is pressure on these budgets locally due to the demographic changes and the increasingly aged population. The CCG has developed a budget based on historic expenditure with additional growth of 5% due to the increased in this area.

7.12 Primary Care and primary Care delegated budgets

The local primary care budget has been developed and applied to help improve quality in primary care and to develop primary care sustainability. The CCG is investing in the GP Five Year Forward View in 2017/18 and hope to enable transformation of General Practice.

The CCGs also manage the delegated PMS and GMS budgets for primary care. The CCGs hope to develop a local charter for primary care which encompasses all of these areas of budget enabling a more flexible primary care offering.

7.13 Summary Financial Plan 2017/18

7.13.1 **A summary of the draft financial plans for 2017/18 have been included in Figure 3** and Figure 4 below. These have been submitted to our local team on the 19th December and therefore are subject to change following the discussions resulting from the issues raised in paragraph 7.4.3.

7.13.2 The above gives a very challenging position with QIPP targets for NHS South Cheshire CCG of £7.526 million (3.00%) and NHS Vale Royal CCG of £4.361 million (3.00%) in 2017/18.

7.14 Contract Offers and Timetable for Finalising Contracts

7.14.1 The CCGs and NHS Providers are mandated to sign all contracts by the 23rd December 2016, with contract mediation starting on the 5th December 2016.

7.14.2 The CCGs have calculated the contract based on affordability and the efficiencies which are required in the system in order to be sustainable health economy going forward.

7.14.3 The contract values have been taken and any recurrent /non recurrent adjustments have been aligned for 2017/18 e.g. slippage on IC Teams has been added back to increase and the non-elective review has reduced the contract values.

7.14.4 National Application of the reduction to the HRG 4+ tariff has been included which has a reduction impact of £2.3million across the two CCGs. The impact of the HRG4 + tariff is however uncertain and appears to be in excess of that notified above. The local calculation is an impact of £3.0 million.

7.14.5 Growth has been applied to the contract activity at 3% but this has been offset by QIPP including the:

- Reduction in GP referrals,
- the reduction in activity due to the removal of unnecessary variation due to Right Care,
- The reduction of activity in respect of integrated community teams,
- The requirement for greater efficiency in the provider sector including the improvement in data availability.

7.14.6 These reductions do represent a challenging environment for providers but it is hoped that working together to introduce more effective patient centred systems and a reduction in unnecessary activities will allow the system to move forward within the business rules required. The CCG is asked to send a reasonable offer and it is hoped that this rationale will support the offers which have been issued.

7.15 Risks

7.15.1 There are a significant number of risks in the current draft financial plan, in brief

- Assumptions in relation to HRG4+ application as noted above
- Impact of non-elective dispute with the main acute provider
- Impact of the Identification Rule Changes
- Growth assumptions in all areas
- Achievement of the brought forward deficit

- Achievement of the high level of QIPP

The detailed financial plans have been submitted separately within the NHS E templates. However, the narrative above relates to the draft submission made on 19th December and discussions are still ongoing with NHS E regarding the final submission on 23rd December so changes may be required.

Section 8 Summary

The CCGs have aligned this document with the recently published NHS Operational Planning and Contracting Guidance 2017-19 and the Cheshire and Merseyside STP. The main purpose of this document is to improve patient outcomes whilst ensuring appropriate utilisation of the financial resource allocated to the CCGs to meet the local demand and needs of our patients. We have a collective responsibility to live within our financial allocation and to ensure that our approach to health care is both evidence based and patient centred.

The focus is delivery of safe, sustainable and effective services for our population across all healthcare settings and working collaboratively with our partners within the allocation that we have available to us.

Everyone accepts that our challenge is significant but we have a responsibility and an opportunity to drive local change. Our expectation is that our providers will want to demonstrate the scale of that ambition and realise the opportunities for local people that the current system creates.

Section 9 – Appendices

Commissioning Intentions Tables

Women and Children Programme

Programme	Description
End of Life Day & Night Paediatric Nursing Service	In rare cases, families need Paediatric Nursing support on call day & night in addition to Hospice care to support home deaths
Gastroenteritis GP Information Leaflet & GP Referral Guide	Encourage adoption of best practice referral criteria and self-management in the community where appropriate.
MMR Uptake Promotion	Encouraging GPs to promote MMR vaccinations opportunistically to improve uptake. Cultural differences may need to be addressed specifically.
Paediatric A&E Nurse Service	The CCGs would commission a Nurse in A&E to manage children without admission to the Paediatric ward where appropriate.
Head Injury GP Information Leaflet & GP Referral Guide	Encourage adoption of best practice referral criteria and self-management in the community where appropriate.
Fever Pathway	Initiation of a fever pathway would support GPs to manage in primary care and follow NICE guidance leading to a potential reduction in admissions.
PEWS Score GP Admissions	GPs take four observations when assessing acutely unwell children and using this to calculate an early warning score. This can be used to aid referral to the hospital or follow an appropriate primary care pathway.
Same day GP appointment for under 5s	Although Right Care data suggests both CCGs experience low relative rates of A&E attendances for under 5s, emergency admissions are significantly higher than peer CCGs. Improved GP access should help reduce A&E attendances and emergency admissions.
Paediatric Dermatology Service	Service would allow management of severe long-term skin conditions such as eczema and would improve use of resources by following prescribing formulae (reducing steroid and antibiotic use).
Patch Paediatricians	Consultants responsible for referrals for particular localities and "reassurance" type clinics based in primary care. Encourages closely working relationships with GPs and upskilling and increasing confidence to manage children in primary care where appropriate.
Bronchiolitis Pathway with GP Referral Guide	Initiation of a bronchiolitis pathway would support GPs to manage in primary care and follow NICE guidance leading to a potential reduction in admissions.

Action on Child Obesity	Public Health indicators suggest that childhood obesity is a particular problem for NHS Vale Royal CCG and the 2016/17 CCG Improvement & Assessment Framework includes indicators on childhood obesity. Work needs to be co-ordinated with Public Health. The CCGs focus needs to be agreed - what is clearly a CCG rather than LA responsibility?
Action on Parental Smoking	Public Health indicators suggest that parental smoking is a particular problem for both CCGs and the 2016/17 CCG Improvement & Assessment Framework includes indicators on smoking at the time of delivery. Work needs to be co-ordinated with Public Health. Engagement with mid-wife's and health visitors will form the basis of any CCG scheme. May help child respiratory admissions too.
Action on Breastfeeding Rates	Public Health indicators suggest that breastfeeding uptake is a particular problem for both CCGs. Work needs to be co-ordinated with Public Health. Engagement with mid-wife's and health visitors will form the basis of any CCG scheme.
Women & Children Performance Dashboard	A dashboard which monitors key CCG women and children indicators will track progress and ensure improvement actions are taken where necessary.
GP Education Events (focus on high referrers)	As per Dr Spooner's suggestion for the focus of the LQS Right Care work. Focus could be as per other areas listed here or emerging analysis of unwarranted variation. Possible topics: Eczema, Bronchiolitis
Carers support	Promotion of best practice carer support by GP practices by working with practice carer leads. Potential to reduce admissions where carers are better supported to access appropriate services and care at home. Potential to improve mental health and wellbeing of carers and families. Requires close co-ordination with the Local Authorities.
Paediatric Phlebotomy Service	Service for 5-15 year olds based in primary care to offer patient convenience and provided at a lower cost to secondary care. Model already exists in Northwich.
Paediatric Observation Unit	The CCGs child admission rate is exceptionally high when compared with peer CCGs due to MCHFT's propensity to admit/record assessment activity as an admission. This leads to significant financial pressures to the CCGs. A Paediatric Observation Unit would enable more efficient use of resources; free up Consultant resource and potential improve patient convenience.

End of Life Objectives

Objective	Outcome	Completion Date
Co-design and co-ordination of care		
Patients and carers have access to specialist palliative care 7/7 and co-ordinated care 24/7	7 day a week specialist palliative care workforce Single Point of Access for specialist palliative care in the community A joined up approach between EoL providers and Continuing Healthcare (EoL fast track)	December 2018 December 2018 December 2017
Explore the potential of a lead provider for the co-ordination and commissioning of EoL care	One Provider co-ordinating the various contracts and provision for EoL care	December 2018
An integrated Palliative Care Nursing Team with a shared MDT	A business case to explore the possibility of an Integrated Palliative Care Team Joint Palliative Care MDT meeting	November 2016 June 2017
To scope the potential of a community led Hospice facility within MCHFT, a care home setting or within Intermediate Care.	A business case to explore the options and feasibility to offer this model of care	March 2018
Personalised Care Planning		
Develop a recognised approach to Advanced Care Planning and plans for care in the last days of life that is transferable across care settings	Advanced Care Planning documentation across care settings Appropriately skilled and educated workforce in using Advanced Care Planning across care setting	March 2018
Work with partners to explore the new DNA CPR framework – RESPECT.	A review to explore the options and feasibility to offer this DNA CPR framework in Cheshire	March 2018
Review, develop and implement improvements to Individualised care plans across care settings to support Preferred Place of Care and best care for patients and families	Individualised Care Plans in place across care settings Workforce confident and skilled to appropriately initiate and utilise care plans	March 2018
Future Life Planning and personal development for public, staff and volunteers on End of Life Care	Increase in Personalised Care Planning for End of life Care	March 2018
Shared Records		
To prevent unnecessary medical intervention to people in their last months, weeks and days of life	EPaCCS recording advanced patient choices Development of the Cheshire Care Record to encompass EoL care advanced patient choices Clear defined performance measures to cross reference data sources to evidence transformation of EoL care	December 2017 December 2017 June 2017

All staff are prepared to care		
Provide opportunities for staff across care settings to be competent, confident and compassionate in delivering high quality EOL care	✓ Deliver a range of blended learning opportunities including facilitation of best practice, study days, short courses and degree level modules ✓ Deliver communication skills training at all levels	March 2018 March 2018
Dementia EOL		
Facilitate practice to enable people with Dementia at the EOL to be cared for and die in the Usual Place of Residence	✓ Establish Dementia EOL Practice Development Team ✓ Pilot and embed Namaste approach in Care Homes ✓ Provide practical advice and education to carers of people with advanced dementia at EOL	March 2018 March 2018 March 2018
Those important to the Dying Person		
To implement a befriending service to the frail elderly and EoL patients	✓ Hospice led operational befriending service providing support and access to other services for frail elderly and EoL patients	November 2017
Engagement with patients, families and carers at EOL	✓ Facilitate the introduction of PROMS and PREMS at EOL to drive and inform service improvement ✓ Public Health promotion Dying Matters Week	March 2018
Enable staff and volunteers to support informal (family) carers to cope and care	✓ Development and implementation of an effective education package ✓ Supportive practical 'courses' and training for carers	March 2018 March 2018

Community Services Transformation	
Project	**Description**
Service reviews - Baseline review of all community services within the contract (timetable set and agreed within Transformation Board) Priority services: Community nursing GP Out of Hours Intermediate care MSK services	The provider will undertake a detailed review of their services following an agreed proforma to include service cost/ staffing/ delivery. Provider and commissioners agree redesign/ change to service specifications aligned to Primary Care Home and Connecting care priorities
Development of Quality markers within an Outcomes framework – linked to service reviews	Extend to all services/ grouped services
Use of District Nursing Quality Markers within the service and measurement against indicators from April 2017	Pilot quality markers and data capture prior to implementing new quality payment mechanism which will relate to it.
Development of a full plan of business intelligence requirements (including DQIP) and reporting framework	Improve capture of patient outcome measures Develop system to capture entire patient journey across a pathway from GP , hospital and community
Direct Access to Physio (via SDIP)	Provider to roll-out physio pilot enabling direct appointments to all practices
Integrated Community Teams (via SDIP) Linked to Connecting Care – Integrated Community Teams Project	The provider will: Review resource requirements around Integrated Community Teams Develop a standardised approach in delivering Integrated Community Teams Establish metrics to measure Integrated Community Team activity and outcomes for patients Identify nominated Clinical Leaders Develop workforce plans
shire care record (via SDIP)	Provision of defined Clinical data sets from the EMIS Community system or preferred Clinical system of Choice to feed into the Cheshire Care Record (CCR). Access and use of the Cheshire Care Record (CCR) for all relevant staff for clinical point of care encounters
Out of hours (via SDIP) This will link to work on ED Front Door	The provider will: Support development and contribute to winter resilience planning Deliver the National Quality Requirements Establish metrics to measure the effectiveness of the Out of Hours service and outcomes for patients Identify nominated Clinical Leaders Develop robust workforce

Streamlining Discharge Processes	
Project	**Description**
Develop an integrated frailty pathway approach in the management of people with complex co-morbidity and frailty across acute, community and primary care.	Encourage best practice developments in relation to the management of people who present with frailty at the front door of ED and providing assessment in the most appropriate setting which improve patient experience and outcomes. Integrated community teams proactively assess people at home with complex need or who are frail utilising a person centred, single comprehensive geriatric assessment to support ongoing care planning. Providers will develop a competent integrated workforce that supports holistic assessment that considers physical, mental, social and functional needs in line with best practice. Providers to develop processes that enable interface community geriatrician to work in collaboration with primary care.
Redesign of health and social care services that support rapid response for those in need of urgent care close to home.	Providers to develop broader collaborative health and social care approach in managing urgent care need in the community by redesigning intermediate care, community rehabilitation, hospital at home and REACT teams, based on best practice. Workforce review to support rapid holistic assessment of need to include mental health, medical, functional and social needs to enable people to stay at home during an acute episode. Revision of person centred approach to care planning with a review by the most appropriate professional. Development of networks that contribute to the management of urgent care need in the right place at the right time in conjunction with the primary care clusters and integrated teams.
Discharge to assess model developed with acute trust and community providers	Review of processes to support timely discharge in order to improve patient outcomes in line with NICE guidance. Processes are put in place to enable people to be directly assessed at home when they no longer need acute care, with a plan in place when necessary, to ensure they can live independently and safely.
Implementation of a safe transfer of care model	Providers develop pathways to enable people that require non acute bed based care to be transferred to appropriate setting for further

	assessment of need. Providers develop pathways that support the timely safe transfer of people who require assessment for long term care.
Implementation of a health and social care integrated discharge team.	In collaboration with social care, health care providers develop a single team that will work together to improve processes to ensure proportional assessment to enable timely transfer or discharge from acute care and reduces the length of stay, delays in transfer of care and improves patient outcomes in line with national benchmarking. The development of the trusted assessor role that facilitates the transfer from acute care to long term nursing or residential care.

Integrated Intermediate Care	
Project	**Description**
Develop opportunities to work in collaboration with third sector to meet local population need.	Providers to develop broader networks and create opportunities to work in collaboration with third sector with a focus on enablement and empowerment to self-manage long term conditions, older people with complex needs. Providers to support the principles outlined with in primary care home which focus on Holistic assessment Care closer to home Personalised care Maintaining independence and resilience
Implement single point of access for rapid response.	Providers will develop a single point of access to enable the development of an enhanced rapid response service for both step up and step down community care. Providers develop processes to improve transfer of care which improve patient outcomes and experience in line with the Connecting Care strategy and primary care home development.
In collaboration with social care, contribute to the community bed needs assessment across Cheshire footprint.	Support the detailed analysis of population need to support the strategy for community bed provision across East Cheshire footprint which is aligned to Connecting Care Strategy of care closer to home. Provider to review processes to ensure that people have achieved the outcomes for community bed based services in line with the aspirations set out in the better care fund schemes.

Integrated Community Teams	
Project	**Description**
Develop business intelligence that is linked to Primary Care clusters to support the development of integrated teams and needs led approaches to local care.	Business intelligence supports the development of risk stratification tools to identify people who are at risk. Business intelligence information to support the development of local priorities based on demographics and need in line with the Primary Care home principles.
Development of integrated community teams	Improved collaborative working to meet local need, utilising skills within defined local teams. Proactive management of those with complex need in the community where possible with clearly defined processes to access specialist support or signposting as required, utilising a person centred, single comprehensive geriatric assessment to support ongoing care planning. Providers will develop a competent integrated workforce that supports holistic assessment that considers physical, mental, social and functional needs in line with best practice. Primary Care Clusters will develop a multi-disciplinary and care coordinated approach in managing local need through the use of a risk stratification process.

Primary Care Home/Care Communities	
Project	**Description**
Development of new models of Integrated Primary and Community care across Central Cheshire, based on the principles of the Primary Care Home	Develop a model of integrated primary and community care that focuses on the provision of care and management of a whole registered population of between 30,000 – 50,000. The Primary Care Home comprises of Primary, Community, Mental, Social and Acute Care providers working together to provide comprehensive and personalised care within the defined population
Identify local priority health needs within each Primary Care Home/Care Communities	Using Public Health Analysis and Informatics to identify the priority health needs for a defined population. Implement risk stratification to manage patients with a long term condition, in the community. Clinical teams working with patients will develop best practice patient pathways. Working with the local authority and the public to identify ways in which the population can feel more supported and confident in their own health and wellbeing, in turn, supporting the prevention of illness or injury.
Develop and agree outcomes to be agreed within each Primary Care Home/Care Community	Develop and implement an outcomes based commissioning approach to Primary Care Home/Care Communities
Right service, Right Time, Right Place	Map the availability of services across each of the Primary Care Home Sites/Care Communities. This will include access to primary care, the range of services available and skill mix of workforce. Develop a multispecialty community provider workforce plan that supports personalised care, enabling the individual to feel supported. Redefine traditional organisational boundaries so that care is delivered in the right place, by the right person. Develop one cross organisational Directory of Services that can be accessed by patients, general public and health / social care professionals. Linked to the 111 and Local Authorities Directory of Services
Working towards the delivery of the Accountable Care Partnership	Work with partners to develop shadow capitated budgets that empower and enable the delivery of better outcomes for patients within budget.

Urgent Care Commissioning	
Project	**Description**
Ambulatory Emergency Care (AEC)	The Ambulatory Emergency Care (AEC) approach is where systems are redesigned to provide same

	day emergency care. The implementation of an Ambulatory Care Unit began during 2016/2017 and will be further embedded during 2017/2018 This will include • Senior clinical input at the point of referral • Clear exclusion criteria based on the NHS Early Warning Score (NEWS) in place • Staffing and resources organised to provide rapid assessment diagnosis and treatment on the same day • The time standards in AEC will match the Clinical Quality Indicators for emergency department: - Initial assessment within 15 mins - Medical assessment within 60 mins - Discharge within 4 hours • Communications and engagement plan to be implemented across the local healthcare system • Clear measures must be adopted and monitored to assess the impact, quality and efficiency of AEC (ref ACU Service Speciation • Patients to be informed early in their journey (ideally by the GP) that they will receive treatment that day and are unlikely to be admitted overnight to manage their expectations and those of their family • Providers and commissioners will have agreed how AEC activity will be recorded, reported and funded • Secondary and primary care services to work together to provide ongoing care outside of hospital to avoid a full admission • The Acute Trust will keep Comprehensive records and discharge summaries sent to primary care within 24 hours
Emergency Department Front Door Streaming	The Primary Care led Front Door at the Leighton site will provide a 'streaming' system to redirect people to the 'right' care and provide primary care and minor injuries services as required. Patients attending the ED will be streamed to the following service areas Self-care/pharmacy Primary Care/ Minors/OOHs Ambulatory Care Unit MH Liaison services Majors/Resus To provide expert care for patients presenting to emergency departments with primary care presentations or minor illnesses. To develop a more integrated, whole system approach to urgent and emergency care.

	To provide expertise about the availability and capability of local health and social care services. To provide a 'streaming' system to redirect people to the 'right' care. To provide expert care for patients presenting to emergency departments with primary care presentations or minor illnesses. To develop a more integrated, whole system approach to urgent and emergency care. To provide expertise about the availability and capability of local health and social care services. Ensure that the most appropriate care is delivered to patients at all times by having the most appropriate HCP available to stream and see patients.
Falls prevention and support	Within our health and social care economy partners recognise the benefits of working jointly for our population to deliver excellent quality of care whilst ensuring the most cost effective return on both the Health and the Social Care pounds. To deliver maximum impact the following plan has been developed to achieve this goal: Improve access to services already commissioned across Health and Social Care by developing a Falls Service Directory (FSD) for use by all health and social care professionals working across NHS South Cheshire CCG and NHS Vale Royal CCG Proactively seek to ensure falls prevention advice is carried out whenever a Health or Social Care Professional visits a patient/client in their usual place of residence Work with Cheshire Fire and Rescue Safe and Well leads to deliver falls prevention advice to circa 15,000 people pa in NHS South Cheshire CCG and NHS Vale Royal CCG during the Safe and Well Home visits Commission Chester based Community Interest Company (CIC), Healthbox, to deliver train the trainer training, exercise classes (in liaison with BRIO Leisure) and support to residential and care homes with higher than average calls to 999, e.g. Mayfield House, Daneside Court, Minshull Country Nursing Home, Morningside Rest Home Commission enhanced, non-medicalised, short-term support and care at home for those that have suffered a fall from ED and Wards via British Red Cross

Mental Health Commissioning	
Project	**Description**
Expansion of Gateway Teams	Expansion of Gateway Teams Embedding and further development of the mental health 'gateway' service, embedding it within primary care services to ensure care and support is available to individuals closer to home
Extension of IAPT services for people with long-term health conditions and co-morbid anxiety and depression.	There are high rates of anxiety and depression amongst people with long-term health conditions. This leads to increased hospital admissions, longer lengths of stay and poorer outcomes and recovery. The recorded prevalence of depression for South Cheshire and Vale Royal is also higher than the national average
Mental Health Crisis Care	Work with partners to develop appropriate support options for people experiencing mental health crisis to support the crisis care concordat. We will continue to work to deliver the Pan Cheshire Zero Suicide plan The CCGs will ensure that mental health is considered and integrated into business planning processes for urgent care and as a result we hope to deliver • An 8.7% reduction in unplanned admissions for mental health conditions • A 30% reduction in non-elective average length of stay for mental health conditions
Mental health awareness	Development of a programme of mental health awareness to improve early detection and help seeking as well as breaking down community stigma
Dementia Care	The CCGs are continuing to build upon the current post-diagnostic support available, including improvements in the continued monitoring available to people who have been diagnosed with dementia as part of the mental health Gateway development. This will include the development of specialist advisors to support other CCG programmes to ensure that people with dementia receive care and treatment in the most appropriate place. By developing these changes in dementia care we hope to deliver • A 20% reduction in A&E attendances for dementia related conditions • A 40% reduction in non-elective admissions for dementia related conditions.
Dementia Diagnosis Rates	The CCGs will continue to work with Primary Care services to improve the diagnosis rate of Dementia to 70% so early intervention and timely support can be provided.

Children and Young People**'s** Mental Health	The CCGs will continue to work with partners to deliver the CAMHS transformation plan in line with the 'Future in Mind' objectives.
Children and Young People's Self harm Pathway	Children under the age of 16 who present at ED at risk of or following self-harm are currently admitted to a paediatric bed. The CCGs are reviewing the pathways to ensure that children and young people receive timely assessments and receive care in the right place.
Transforming care for people with a learning disability	Continued development and implementation of the Transforming Care partnership plans with local government partners. By 2020 20% of people in receipt of services due to a learning disability will have a Personal Health Budget. Work with partners and key stakeholders to co-produce a more flexible model of community provision. Build on work already developed to provide a more flexible co-ordinated offer for children with learning disability leading up to and at transition.
Improved physical health care for people with a learning disability Improve bed based environments for individuals requiring further assessment. Improve support for Carers	Work with Primary Care services to ensure that people with a learning disability have appropriate access to annual health check The CCGs are to commence work with independent providers to look at supporting the development of Extra Care type facilities for individuals with a learning disability requiring further assessment or ongoing care in the community. The CCGs will continue to work with partners to ensure carers and families are supported and that services are continual improved to meet the needs of carers locally.

Cancer Services Commissioning	
Project	**Description**
Driving Earlier Diagnosis	Raise community awareness and provide education on early signs and symptoms of cancer through the "Action on Cancer" project Develop the cancer champion model to enable community volunteers to share messages of early detection of cancer Improve uptake to cancer screening programmes through a number of initiatives Empower our local pharmacies to recognise, act upon and signpost people they see who potentially have early signs and symptoms of cancer Expand direct access to chest x-ray for patients with possible early symptoms of lung cancer across the CCG areas Provide to our GP's clinical decision and assessment tools, referral protocols and education to facilitate earlier suspicion of cancer
Having a positive experience of cancer care and support	Provide a framework for Primary Care in delivering a Cancer Care Review that is integrated with the patients pathway of care Implement timed pathways for all cancer types, but initially Lung, Upper GI and Colorectal to speed up diagnosis and delivery of first treatment for cancer Test out the new Find out Faster recommendation to enable people to have cancer ruled out or diagnosed quicker from GP referral Review the pathway for Upper GI cancers Work with Greater Manchester and NHS England to redesign the Urology Cancer pathway to be compliant with NICE Improving Outcome Guidance Work with the Christie and MCHFT to bring oncology care as local as possible Engage and support Greater Manchester with the development of a Cancer Alliance in line with the Cancer Strategy Ensure that South Cheshire and Vale Royal are integrated into the work of the Greater Manchester Cancer Vanguard
Enjoying a better long-term quality of life after cancer	To risk stratify treatment plans with clear requirements for follow up and self-care for Breast, Colorectal and Urology Cancers. Ensure that all patients have access to a Cancer Nurse Specialist throughout their cancer care Ensure access to local Health and Wellbeing events for people affected by cancer Develop the cancer pathways to ensure that all patients have a Health Needs Assessment and care plan at the point of a cancer diagnosis and at the end of active treatment

Continuing Healthcare

Project	Description
Strengthen person centred approach to Continuing Healthcare, Funded Nursing Care and Complex Care by working at scale during 2017 and beyond	Work with staff, key partners and patients to implement the CHC strategic plan through focusing on the ten key commitments from "Leading change, Adding value" to ensure patients receive high quality services now and into the future years. Contract6 framework implementing a Dynamic purchasing system, review of bed utilisation Review Domiciliary complex packages Increase in personal health budgets Review of joint packages of care with Local Authorities, including section 117 and the NHS contribution process
Align the person centred approach for people with complex care needs and the interdependencies with Transforming care	Review all out of area placements Work with the local market to develop flexible co-ordinated community service provision Use the evidence base to enable CCGs to design and commission services for the future
Discharge to assess model developed with acute trust and community providers	Work across the health and social care system to ensure compliance with the NHS Continuing Healthcare Framework Focus on undertaking assessments in an appropriate non-hospital based environment

Care Homes

Programme	Description
To ensure we have a joint Care Home contract in place	A joint Care Home contract with the Local Authority will ensure a consistence and collective approach to quality of care with care homes. This will enable CCGs to work closely with partners such as the CQC and Health watch to ensure residents and families are happy with the care they receive
Redesign of current Intermediate and transitional bed based care and assessment service	The CCGs recognise that not all patients are able to return home directly from hospital and may require a period of assessment and rehabilitation. The care and support residents may require has shifted and a review and the current transitional beds are required taking in the challenges around appropriate dementia care and supporting those residents to return home with the right step down support.
A clear Market Position Statement to Providers.	The CCGs will work with the Local Authority to produce a Market Position Statement for providers; this will enable providers to develop their services to meet the needs of individuals. In particular supporting residents that require a higher need of clinical care
Exploration of alternatives to 24hr Care.	As CCGs we accept that not all residents may wish to go into a Nursing Home. Through the work with the local authority we will explore additional Extra Care alternatives that may include intermediate care capacity. There is an acknowledgement that alternatives to care are required especially for individuals who are under 65yrs and require both health and social care support.
Additional training and advice for care homes.	The CCGs presently support care homes with additional training and support needs, especially. Over the next 2yrs the CCGs are to work with partners to enhance the quality of care provided to resident around end of life care, pressure area care and continuing health care.
Care home forums	The CCGs are to build on the current joint work with the Local Authority to further develop the care home forum. This will provide support information and guidance to care homes and enable care home managers to have a forum to highlight any areas of development.

Primary Care	
Project Area	**Description**
Delegated Commissioning (General Practice)	Continuing to ensure high quality General Practice provision across NHS South Cheshire CCG and NHS Vale Royal CCG using Delegated Commissioning Functions. To support Practices through resilience and funding streams where available, underpinned by their key role in new models of care To support practices to deliver the Directed Enhanced Services, to improve the services provided the local population
Development of a Primary Care Charter	To ensure that patients receive the same level of high quality care across the CCGs in respect of general practice services. Regardless of which surgery patients are registered with, the CCGs will agree and commission a revised offer for Primary Care that supports aspirational standards. The plan is to roll this out during 17/18 to support Practices not only in terms of their sustainability but to support transformation /new models of working
Supporting Further Investment in Primary Care (Planning Guidance Cross Reference 1.2 and 1.2.1) (GPFV)	The CCGs will develop plans to invest the £3.00 per head to (1) Stimulate development of at scale providers for improved access (2) stimulate implementation of the 10 high impact (3) free up GP time and (4) Secure sustainability of General Practice as part of the GPFV plans
Deliver the Online General Practice Consultations Programme (Planning Guidance 1.2.1b) (GPFV)	In partnership with our Practices, the CCGs will deliver the requirements of the national specification (awaited) Ensure that the delivery of this programme is co-ordinated with the development of Primary Care Home/Care Communities
Deliver the Training Care Navigators and medical assistants for all Practices Programme (Planning Guidance 1.2.1 c) (GPFV)	In Partnership with our Practices, the CCGs will deliver the requirements of the national specification (awaited) Ensure that the delivery of this programme is co-ordinated with the development of Primary Care Home/Care Communities
Support the delivery of the General Practice Resilience Programme (Planning Guidance 1.2.1d) (GPFV)	The CCGs will continue to support Practices in partnership with NHS England where there are resilience/sustainability issues through access to the Resilience funding (Held by NHS England)
Deliver Improved Access to General Practice (Planning Guidance 1.2.2 GPFV and 1.3.1 GPFV)	Using the Prime Ministers Access Fund, the CCGs will support primary care to increase capacity for a wider range of clinical appointments, improve access to same day and pre-bookable, 7am to 8pm and at weekends. Ensure clear pathways to access the additional capacity, through 111, GP OOH and through new digital channels. To ensure appointments are

	easily accessible for those with an urgent care need. Develop and implement a plan for how digital approaches will support patients accessing appointments Commission alternative solutions, the voluntary sector providing support and signposting for patients, referred by practices to address health inequalities. Support increasing access for practice clinical teams, including pharmacy, physiotherapy and nursing to ensure the right professional is seeing the patient for their healthcare need.
Deliver the transformation benefits of the Estates and Technology Transformation Fund Primary Care (Planning Guidance 1.2.3)	Deliver and Implement the ICT technology scheme for South Cheshire and Vale Royal. Deliver and implement estates improvement plans to increase clinical space and provide dedicated rooms for counselling, allied health professionals, specialist clinics and diagnostics in the community. *Please note: these work streams are dependent on bids being successful in round 2 of NHSE bidding process*
Deliver Primary Care Redesign (1.3)	***The CCGs will support practices through a transformation project that will include the 10 high impact changes.*** Ensure consistent of quality and access offer across practices Expand services in scope to meet new challenges and to deliver better outcomes Work with practices to deliver care via the current model of small autonomous teams but develop competent organisational and wider sector outcomes. Working with the GP Alliance work with practices as a collective, to deliver the transformational changes required at pace and scale.
Support the Implementation of the Time For Care Programme (1.3.2) (GPFV)	The CCGs will support and work with Local Practices to roll out the Time For Care Programme Map the ten high impact changes against the transformation plans and aligned to the NHSE primary care capital funds. Ensuring consistent delivery of the ten high impact changes across Vale Royal and South Cheshire, as part of transformation programme.
Support the delivery of training for reception and clerical staff (1.3,3) GPFV and online consultation systems	The CCGs will work with local Practices, NHS England and the LMC to design and roll out a local Programme to ensure all staff are trained in active signposting and documentation training
Workforce (1.4 PG GPFV)	The CCGs will develop a workforce strategy as part of their GPFV plans to support general practice resilience and new ways of working/models of care/expanding multi-

	disciplinary teams/skills mix
Practice Infrastructure (1.6 PG GPFV)	Work with practices to identify infrastructure needs ensure that there is a rolling programme of development that supports the vision of practices to work in small autonomous teams with community and acute providers supporting practices as part of the Primary Care Home/Care Communities. This will be done through the Estates and Technology Fund and the GPIT Fund, capital funds to support developments in primary care.

Prescribing and Medicines Optimisation

Project	Description
Enteral Feed Prescription Management Service	This project will build on existing joint working to develop shared guidance on product choices of oral nutrition supplements (ONS) and a “food first” approach to managing disease-related malnutrition. The project would aim to reduce the total cost of providing ONS products below the current level, which is above the England average per head of population. A 5-10% reduction in annual costs would represent a saving of £90,000 to £180,000 across NHS South Cheshire CCG and NHS Vale Royal CCG. The Project would entail: Review of the terms of an historical Enteral Feed Tender that limits the recommendations to products provided by a single company. Commissioning / procuring a dietetic service that would take clinical, financial and operational responsibility for the management of ONS supplied in the community. Reconfiguring the dietetic service in this way would remove the cost of prescribed Oral Nutritional Supplements (ONS) from the general practice prescribing budget, and reduce the administrative burden of prescribing these items in general practice.
Stoma Product Prescription Management Service	This project would aim to reduce the total expenditure on stoma appliances by 20% to bring them in line with the England average, while also seeking to improve the clinical support for patients from specialist nurses, while relieving general practice of the administrative burden of liaising with Dispensing Appliance Contractors (DACs) over prescribed appliances. The project would entail: Commissioning a service to place clinical and financial control for the spend on stoma appliances with a service comprising: Clinical oversight from specialist nurses to initiate, review and support patients to receive the most appropriate products Administrative support for repeat prescription management to minimise waste Removal of the general practice team from the stoma appliance supply chain. The GP would no longer be required to be involved in the process freeing up clinical and administrative time for other work. The patient would receive an improved clinical experience and

	the opportunity for waste reduced considerably. To achieve the England average cost per 1000 patients would require a 20% reduction in costs per 1000 patients yielding approximately £300,000 in cash releasing savings (some of which would need to be invested in delivering the service). If a successful model can be developed for this type of prescription management service, other areas that could be explored include dressings and urological appliances.
Polypharmacy and Medicines Optimisation	The Medicines Management Team has worked with colleagues to develop a policy on Polypharmacy and Medicines Optimisation in 2016-17. Within current resources, the expectation is that the implementation of the policy will fall to general practice to incorporate into existing systems. Pharmacy professionals are in an ideal position to work with patients and other healthcare professionals to identify, prevent and resolve medicine-related problems. GPs, practice pharmacists, MMT pharmacists or other services could be commissioned to review patients on multiple medications that either increases the risk of harm or that offer limited benefit. For example, certain medicines can increase the risk of acute kidney injury, particularly in circumstances where patients become dehydrated and in patients with conditions such as heart disease, diabetes and kidney/liver disease. Screening the medication records of patients in at-risk groups could identify the need to stop some medicines, either permanently or in situations where the risk of acute kidney injury is increased. Other examples include reviewing patients who may have been prescribed antipsychotics to manage behavioural and social symptoms of dementia (a practice that is no longer recommended), and trying to reduce the number of pain killers required to achieve optimal functional management of pain. Depending on the resources needed to prepare and deliver a package of polypharmacy and medicines optimisation tools and services, savings of around 1-2% of the prescribing spend may be achieved. This work stream will further strengthen the work on patient-led repeat prescription ordering systems conducted in 2016-17.
Medicines Management Individual Funding Requests (IFRs)	Between 1st April 15 and 31st March 16, the IFR team received a total of 33 IFRs for NHS Vale Royal CCG and 50 IFRs for NHS South Cheshire CCG. These requests relate to 15% and 16%

	respectively of the total of all IFR requests for each CCG but cost proportionally more. The project will entail an in-depth retrospective review of all medicines IFR received in the previous financial year to identify Inappropriate IFR requests, for medicines which are in line with NICE /local commissioned decisions that do not require IFR but for which a Prior Approval process via Blueteq is already in place. Trends and cohorts which have reached the threshold for a commissioning decision and require completion and submission of a business case/service development by the clinician for consideration by the CCGs. Prospective monthly review of Medicine IFR requests to identify potential cohorts, facilitate validation and challenge of invoices where there is no evidence of an approval.
Review of Think Pharmacy Services commissioned by CCGs	The CCGs have commissioned Think Pharmacy Services from community pharmacy providers. The Services will be reviewed so that services commissioned in 2017-18 are more closely aligned with strategic pieces of work within the CCGs, and take account of the changing contractual framework within community pharmacy. The project will entail: Review of the Think Pharmacy Minor Ailments Service to bring the service in line with the policy to reduce GP consultations and prescriptions for minor conditions suitable for self-care Review of the Think Pharmacy Urgent Palliative Care Medicines services to assure the CCGs that community pharmacy can provide urgent medicines for end-of-life patients from strategic locations Continued engagement with the Pharmaceutical Local Professional Network to develop ongoing opportunities to commission appropriate services from community providers to complement NHE England's commissioning arrangements

Contract Management

The elements of contract management below are identified to comply with the themes of the STP in that they encourage coding, counting and charging to be applied correctly to facilitate the management of variation and the transformation of the system based on accurate and correct funding of service areas.

The contract management criteria for the contracting round for 2016/17 to 2017/18 are set out below.

- **Managing care in the most appropriate setting** with a focus on prevention, integration and demand management.
  - Where a provider can use differing points of delivery for a procedure, the CCG will pay the lower tariff unless it is agreed in advance that the more costly point of delivery remains appropriate.
  - Ambulatory Care conditions will not be paid for as an inpatient, ambulatory care conditions shall be paid for at a level appropriate to the cost of the service delivered.
  - The Procedures of Limited Clinical Value Policy must be followed at all time, where prior approval is not given then any activities will not be paid for.
  - The provider shall at all times seek to reduce the cost of activity to the system to ensure that the system lives with the financial allocations as detailed.

- **Reducing unwarranted variation and, with partners, progressing service and organisational reconfiguration.**
  - All activity undertaken in acute services is open to challenge over the classification and coding by the acute provider. Incorrect coding is that which does not follow the guidance and is inconsistent with the actual activities being undertaken.
  - Where an incorrect tariff has been applied the CCG will not pay for the activity unless the appropriate tariff is applied.
  - Validation checks will be carried out in line with Flex and Freeze dates.
  - Corrections will apply from the point at which the tariff was originally misapplied.

Please note that the CCG will not pay for:

- multiple outpatients taking place on the same day
- outpatients where the patient is an inpatient except where the outpatient relates to the patient's condition and is considered urgent.

- activity where the CCG is not the commissioner
- activity where the information recorded by the provider is not adequate to identify the appropriate coding, counting or tariff.
- any changes in coding and counting which have not been formally agreed with the CCG prior to implementation whether the change in coding is incremental or applied on a single date
- non-elective activity above the national average non-elective admissions per 1000 patients, based on HES admissions data (MAR); reductions will be made based on the average non-elective admission target in the previous month.
- outpatient follow ups above the peer average for each specialty.
- Best practice tariffs where there is not a clear demonstrable improvement in outcomes or where the pathway cannot be demonstrated to meet all of the specific criteria / standards

  - The CCG shall undertake audits of provider coding and counting as required. All findings of the audit will be implemented from the date any errors were initially made (not limited to the current financial year)
  - Where individual patient activities are found to be incorrect the provider will correct these.
  - All activity must be undertaken in date order, where patients are not treated in this way the CCG will not pay for the taken out of order unless the provider supplies adequate information to support an increased level of urgency.
  - Commissioners and providers will jointly review the effectiveness of the services we commission with the aim of eliminating waste, delay and duplication and by services not delivering what they were intended to deliver The CCGs reserve the right to move to a prime provider model for both elective and maternity care during this planning period. The implementation of HRG4+ is anticipated to demonstrate a reduction in total contract expenditure (national modelling and assumptions) across secondary care providers. This is expected to be delivered locally and has already been included in the initial financial plans submitted to NHS England. Any cost pressure towards the commissioning system driven by case mix adjustment or re-profiling of activity will not be recognised or paid for if this is purely as a result of the introduction of HRG4+ (noting that the local system has agreed to move away from a PbR contract regardless of these issues).

- **Change and evolve how we work together** with an expectation of this being across both provider and commissioning approaches

  - There will at all times be transparency in discussions and decisions being made via the contract

- Commissioners and providers will jointly review the effectiveness of the services we commission with the aim of eliminating waste, delay and duplication and by services not delivering what they were intended to deliver.